State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.3 Table of Contents

1.4 Overview of the State

Vermont is located in the northeast region of the United States, a New England state sharing its northern border with Quebec, Canada. It is a rural state with a population of 590,883 in 1998, as estimated by the U.S. Bureau of the Census. Vermont was the second fastest growing state in New England from 1990 to 1998, increasing 5.0% from the 1990 census count of 562,758. The most recent estimates (1998) from the Bureau of Census on race and ethnicity indicate that 98.4% of Vermont's population is White, however, racial and ethnic minority populations are growing at a much faster rate than the overall population. Both the Black and the Asian and Pacific Islander populations have increased by over 50% since the 1990 Census. The Hispanic population has increased by about 40%, while the American Indian, Eskimo and Aleut population has declined by about 11% since the 1990 Census. Of the 1.6% of Vermont's population comprised of racial/ethnic groups, approximately half (50.6%) are Asian/Pacific Islanders, 32.3% are Black/African American, and 17.1% are American Indian. Less than 1% of the population (5,151) is Hispanic/Latino, according to the 1997 estimates. Vermont's age distribution is similar to the national and New England distributions, although growth rates for different age groups in Vermont are quite different from the regional and national rates. The 45-65 year old group is the fastest growing segment of Vermont's population with a growth rate of 32.1% from 1990 to 1998. The under five segment of Vermont's population decreased by 22.0% over the same period, in sharp contrast to the national increase of 1.1% for that age group. This population decline reflects the decrease in the Vermont birth rate, which has been slowly and steadily decreasing since 1989.

Of the 251 towns and cities in Vermont, only seven have total populations that exceed 10,000. Vermont's largest city is Burlington, with an estimated population for 1998 of 40,727. Vermont has 14 counties, and one metropolitan statistical area (MSA), the greater Burlington area. The estimated population of this MSA is 165,306 for 1998, representing approximately 28% of the state's population.

The 1997 Vermont fertility rate was 48.9 live births per 1,000 women ages 15 through 44, down from 50.1 in 1996, and the lowest ever recorded in the state. Slightly more than half of all births (51.1%) in 1998 were to women in their twenties, and women age 30 and over accounted for 41% of births. Also in 1998, women age 15 through 19 accounted for 7.8% of births, down

from 12.7% in 1980.

Vermont's governmental structure consists of state government and town/city government, with essentially no county governmental structures. Vermont citizens participate directly in town/city government through annual town meetings. Vermont is divided into 12 Agency of Human Services districts, each with a district office of the Vermont Department of Health headed by a District Director (Vermont's equivalent to a local health official).

Vermont is a scenic and mountainous state. However, its rural nature presents the issue of sparse populations having ready access to resources and services. Residents living in isolated areas of the state may have special difficulties accessing services and medical care (particularly in the harsh winter months) due to their remote locations and the less than optimal road conditions. Another challenge for the delivery of Title V services is the fact that a sizeable proportion of Vermonters are living in poverty (an estimated 10.8% in 1998), and many more Vermonters are living very near the poverty level. Approximately 1 in 8 Vermont children lives in poverty. Also, Vermont has a migrant worker population which is predominantly white.

Since 1980, the Refugee Resettlement Program has relocated close to 4,000 refugees to Vermont, increasing the cultural and linguistic diversity of the population being served by the health care and social service system of the state. Recently resettled refugees have arrived primarily from Vietnam and the Balkans, along with a rise in refugees from Africa. This population of new residents may have more difficulties in accessing the health care system and other services because of language barriers, cultural differences, and unfamiliarity with the American health care system and available health resources. In addition, there is a shortage of trained interpreters and translators. Addressing the needs of this group is another challenge in the delivery of Title V services.

Vermont Health Care Reform

In July of 1995, Vermont's Medicaid 1115 Research and Demonstration Waiver application to implement the Vermont Health Access Plan (VHAP) was approved. The waiver has allowed for a basic package of insurance coverage for previously uninsured adults with incomes up to 150 percent of the federal poverty level (FPL), and for mandatory enrollment into a managed care plan for nearly all Vermonters who have Medicaid/Dr. Dynasaur (the name for children's Medicaid)

insurance as their sole source of health insurance. Individuals with another source of insurance, or who are recipients of Medicaid Home and Community-Based Waiver Services, or who are in the Medicaid Hi-Tech program, remain covered by the Medicaid fee-for-service model.

The 1115 Waiver was up and running as of January 1, 1996. Enrollment into managed care plans began on October 1, 1996 for Medicaid families, children, and newly insured VHAP enrollees. One managed care plan, Kaiser Permanente/Community Health Plan/Access Plus, participated at the outset, and a second, Blue Cross/Blue Shield Blue First, joined as of January 1, 1997. Vermont is fortunate in that virtually all medical doctors in the state accept Medicaid insurance. A November 1997 survey that took place since the inception of VHAP indicated that an estimated 93.2% of Vermont children had health insurance coverage.

In October 1998, the children's Medicaid program, Dr. Dynasaur, expanded eligibility for children birth to 18 years to include those with incomes up to 300% FPL, further reducing the percentage of Vermont children who are uninsured. (Vermont had been covering children with incomes up to 225% FPL since the early 1990's.)

As children in protective custody are enrolled into Medicaid managed care, the CSHN director and a public health nursing specialist meet twice a month with Vermont's child protection agency, called the Department of Social and Rehabilitative Services (SRS), Medicaid, and Medicaid managed care representatives to review the care of the SRS foster children who have the most complex health or mental health needs.

The MCH Director and other key MCH staff continue to be involved in the administration of the Medicaid program. Most significantly, this past year, through EPSDT and CISS grant responsibilities, the MCH Director and program heads provide leadership for the development and production of Vermont's new periodicity schedule for children.

In Vermont, individuals with disability-based SSI are also eligible for Medicaid. A study group examined strategies for enrolling SSI recipients in the managed care plans. After a brief pilot in two counties, it was determined that the best form of managed care for these individuals would not be a pre-paid HMO model, but rather a primary care/case management model (PCCM). This PCCM program began in October, 1999.

In early 1999, Kaiser indicated that it was no longer interested in continuing in the Northeast and was looking for a buyer. By summer 1999, it was becoming clear that budget

negotiations for the next calendar year were going to be difficult. No buyer came forward for the Vermont portion of the HMO and the state was unable to secure agreement with Blue First for ongoing costs.

The Office of Vermont Health Access (OVHA) was prepared to build on the PCCM program, now called PC *Plus*, and moved all beneficiaries from the HMO plans to PC *Plus*. This task was completed by April, 2000.

The Child Health Insurance Program (Title XXI)

Vermont's application for the Child Health Insurance Program (CHIP) has been approved, but with modifications to its original application. Children who have no other insurance coverage are enrolled in PC *Plus* and are eligible for the Title XXI enhanced federal match rate. This group of approximately 1,600 children comprises the Vermont CHIP enrollment. Children who have another form of insurance are not eligible for CHIP, but continue to be eligible for the expanded Medicaid/Dr. Dynasaur program described above. These under-insured children are enrolled with Medicaid as a secondary payer of last resort, after insurance (or commercial HMO), on a fee-for-service basis. Vermont is exploring strategies to promote enrollment in these expanded insurance opportunities for children. With these advances in coverage, we believe that universal access to health care has been achieved for children in Vermont.

Current Priorities

Vermont continues to prioritize the strengthening of community based and statewide systems to support families, including those with children with special health care needs. Vermont is considered exemplary in its successes in providing health insurance for its citizens. Presently, 93.5% of Vermont residents have some form of health insurance, including essentially all children and adolescents. However, efforts continue to address families who may have some form of insurance but who are under-insured. Vermont has received a Robert Wood Johnson grant (Covering Kids) to develop and provide enrollment outreach to such families. Another area in need of attention is the utilization of health care among school-age children and adolescents; the School EPSDT Health Access Program is engaged in efforts to address this issue. Dental health care access is a longstanding problem for Vermonters and one that the Department of Health is

addressing through the activities of the Dental Health Unit. Strategies include outreach to families via schools and other services, increasing dental reimbursement rates, and increasing data tracking abilities via linkages with Medicaid.

Although Vermont has made significant progress in lead poisoning screening, there continues to be room for improvement: in 1999, 63% of 1 year olds were screened, whereas the goal is 75%. VDH is undertaking efforts to increase lead testing (see description of the activities of the Childhood Lead Poisoning Prevention Program in this document).

The mental health needs of children and families are also of special concern and receive attention across a number of agencies within the Agency of Human Services. One focal point for activities related to children's mental health is the Children's UPstream Services (CUPS) grant, a 5-year project to support and preserve families of young children who are at risk for experiencing severe emotional disturbance (SED).

The new Vermont EPSDT periodicity schedule has been important in the effort to promote new approaches to child and adolescent health supervision, consistent with the current emphasis on health promotion and the prevention of psychosocial morbidity. A providers' tool kit has been developed including screening tools and incorporating information related to the EPSDT periodicity schedule. The tool kit is being distributed to pediatricians, nurse practitioners, family practice physicians, and school nurses. Ongoing efforts are being directed toward systems development with regard to the implementation of these standards of practice.

The Health Department has also implemented an award winning media campaign to promote communication between parents and their children (ages 11-15 years) about the relationship between the use of alcohol and drugs and vulnerability to sexual advances. In light of welfare reform, day care quality, affordability, and availability has become an even greater priority. VDH is continues to expand the statewide system called Healthy Child Care Vermont, which provides technical assistance to child care providers about key health and safety issues. In addition, the Division of Community Public Health participates in a state advisory committee on welfare reform. The welfare reform advisory committee continues to focus on child care and transitional child care for parents receiving ANFC, the draft policy that exempts women who are trying to escape family violence from the work requirements under welfare reform, and ANFC parents' transportation needs relating to employment or training.

The Department of Health has become increasingly concerned about the high rates of marijuana and alcohol use among adolescents in Vermont, and the state has a federal grant from the Center for Substance Abuse Prevention that provides funding for research-based community programs to prevent alcohol and drug use among Vermont youth. In addition, the Office of Minority Health is increasing its activities to evaluate the substance abuse practices of Vermont's minority youth, including those of racial, ethnic, refugee, immigrant and GLBTQ minorities. As the needs of these minorities are further identified, OMH will be working with other divisions of the VDH to develop specific programs to support these subpopulations.

New initiatives are being planned to combat obesity and promote physical fitness in all ages, including women and children. Also, an Injury Prevention Project has been newly formed and is exploring issues of childhood morbidity and mortality from injuries.

Environmental health issues that are of special concern for children's health continue to be a focus of attention for assessment and planning. Collaboration continues between the Division of Community Public Health and the Division of Health Protection's Environmental Risk Assessment Unit in the specialized training of local environmental designee public health nurses.

Infant mortality reduction continues to be a high priority for the Health Department. Two campaigns have been outlined toward the reduction of SIDS and reducing the exposure of infants and children to second hand smoke. VDH continues to focus on the prevention of preterm deliveries and identification of psychosocial risk factors that put women at risk for preterm delivery.

The Office of Minority Health is supporting the operationalizing of the Department of Health's resolution to eliminate racial and ethnic disparities. In addition, the OMH is facilitating the development of strategies and recommendations from the Minority Advisory Committees and the Physicians Healthcare Survey.

CSHN is emphasizing planning for systems of infrastructure building. Other priorities include enhancing the system of universal hearing screening, developing systems support for the medical home concept, evaluating supports for youth as they transition to adulthood, and strengthening community support services for families.

Vermont Department of Health Planning Initiatives

Vermont Health Plan: A Call to Action was released at a press conference on June 15, 1999. In keeping with the enabling legislation, this plan is intended to "…set[s] forth the goals and values of the state." The document examines health issues in five broad categories: human biology, habits and behaviors, the environment, economics and social factors, and health care. Issues and needed actions that are critical to the health of mothers, children and families are incorporated throughout the document. The first edition of the Annual Action Plan was released in the Spring of 2000. This comprehensive document draws on the Title V plan and other documents to identify strategies for addressing these issues.

The Health Department has begun work on *Healthy Vermonters 2010* through the selection and prioritization of objectives found in the draft document, *Healthy People 2010 Objectives.* This process will allow Vermont to focus attention on those national objectives that are of greatest concern for its citizens. The national objectives for Maternal, Infant and Child Health and Family Planning will be adapted for Vermont's public health needs. This process will be completed in the year 2000 and the selected objectives and related strategies will be coordinated with the planning efforts described in Title V and the *Annual Action Plan*.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Agency of Human Services is one of the agencies of state government, and is headed by the Secretary of Human Services, who reports to Vermont's governor. The Vermont Department of Health (VDH), within the Agency of Human Services (AHS), administers the Maternal and Child Health (MCH) Block Grant, also known as Title V. Most Title V activities occur through two of the six divisions of the Vermont Department of Health: the Division of Community Public Health and the Division of Health Improvement. Since 1995, the Division of Health Improvement has encompassed the former Division of Children with Special Health Needs. The MCH Director has the responsibility for the implementation of the entire Title V grant. As part of the oversight of the grant, the MCH Director meets regularly with the appropriate partners within VDH and with

outside contractors receiving funds from Title V. (See included organizational charts.)

Relevant Vermont Statutes

Listed below are some important laws from the Vermont Statutes Annotated (VSA) related to Title V. The full, but not "official", text of these statutes may be accessed on the Internet at:

http://www.leg.state.vt.us/statutes/statutes.htm

STATUTE	SUMMARY OF LEGISLATION
18 VSA § 116	Provides that the Board of Health continue the existing health service for mothers and children established in a manner harmonious with parts one and two of Title V.
3 VSA § 3003	Makes the Board of Health an advisory agency with the powers and duties of the Board vesting in, and to be exercised by, the Secretary of Human Services.
33 VSA § 4701	Develops statewide capacity to enhance the ability of families to protect, nurture, educate, and support the development of their children so that each child will enter kindergarten ready to succeed in school ("Success by Six").
18 VSA § 1755(c)	Requires all health care providers who provide medical care to insure that parents and guardians of children below the age of six are advised of the availability and advisability of screening and testing their children for lead poisoning in accordance with Department of Health guidelines.
18 VSA § 1759	Mandates all owners of rental target housing and child care facilities to perform certain essential maintenance practices on their property in order to help prevent lead poisoning of children.
21 VSA § 472a	Entitles employees to take short-term family leave for certain purposes such as to participate in a child's preschool or school activities or to respond to a medical emergency.
33 VSA § 5551	Gives the Department of Social and Rehabilitation Services powers and responsibilities regarding the administration of juvenile probation including the authority to enter into contracts with community-based agencies to provide probation services.
7 VSA § 1003	Prohibits the sale or provision of tobacco products to persons younger than 18, bans vending machines, and contains other provisions designed to restrict minors' access to tobacco products.
23 VSA § 1216	States that a person under the age of 21 who operates a vehicle on a highway when the person's alcohol concentration is 0.02 or more commits a civil traffic violation and is subject

	to driver's license suspension.
18 VSA § 1129	Requires health care providers to report, to the Department of Health, all data regarding required immunizations of children under 18 within 7 days of the immunizations, and enables the Department to use the data to create a registry of childhood immunizations.

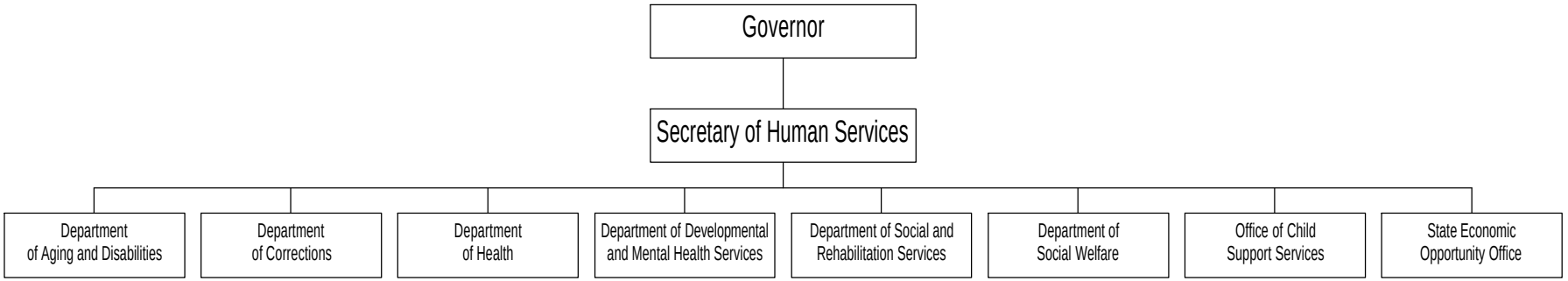
STATUTE	SUMMARY OF LEGISLATION
8 VSA § 4089e	Compels insurers to provide coverage for medical foods prescribed for medically necessary treatment for inherited metabolic disease, which is defined as a disease caused by an inherited abnormality of body chemistry for which the State screens newborn infants.
7 VSA § 658	Makes selling, furnishing, or knowingly enabling consumption of alcohol by minors a crime punishable by a fine not less than $500 nor more than $2000, or imprisonment not more than 2 years, or both. If an illegal sale results in death or serious bodily injury, the penalty is imprisonment for up to 5 years and/or a $10,000 fine.
24 VSA § 4409(f)	Specifies that a Vermont registered or licensed family day care home serving 6 or fewer children must be considered by right to constitute a permitted single-family residential use of property in order to assure greater access to child care.
7 VSA § 501	Holds a social host who knowingly furnishes intoxicating liquor to a minor liable if the social host knew, or should have known, that the person who received the intoxicating liquor was a minor.

In addition to the above statutes, two major acts of the Vermont Legislature have formed what is called the "Dr. Dynasaur" program. Under Act 94 (1989) and Act 160 (1992), this program is a state-funded health assistance program for children under 18 and pregnant women who do not qualify for traditional Medicaid. Further specific information about this program may be obtained at the following website:

http://www.state.vt.us/governor/dynasaur.htm

The charts on pages 13 to 16 depict the current organizational structure of the Vermont Agency of Human Services and the Department of Health.

Fiscal Year 2000 Budget
Organization Chart
Vermont Agency of Human Services



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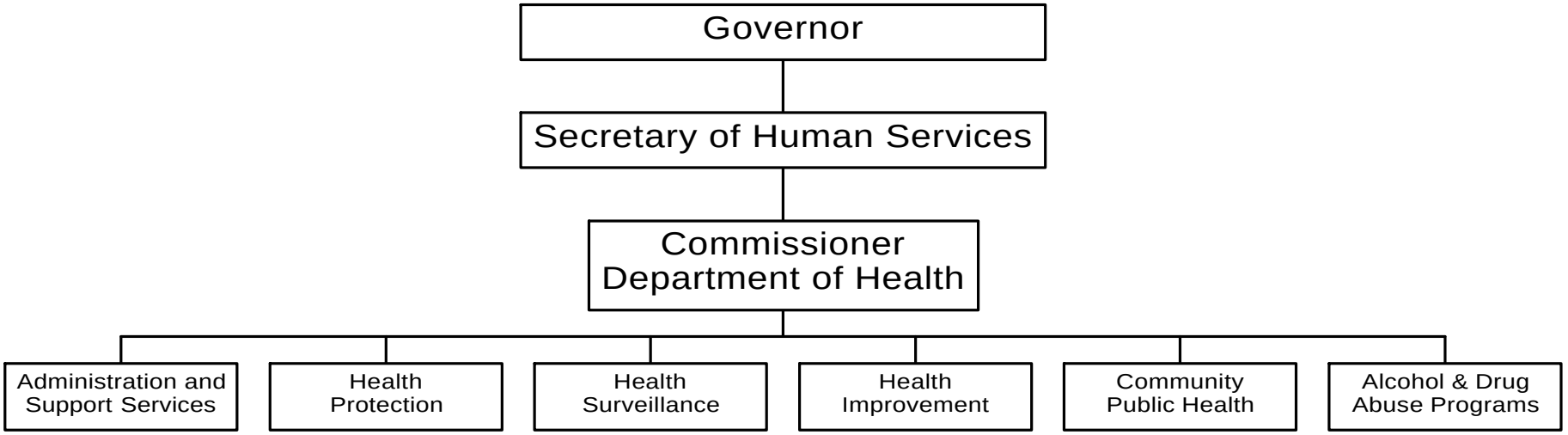
Fiscal Year 2000 Budget
Organization Chart
Vermont Department of Health



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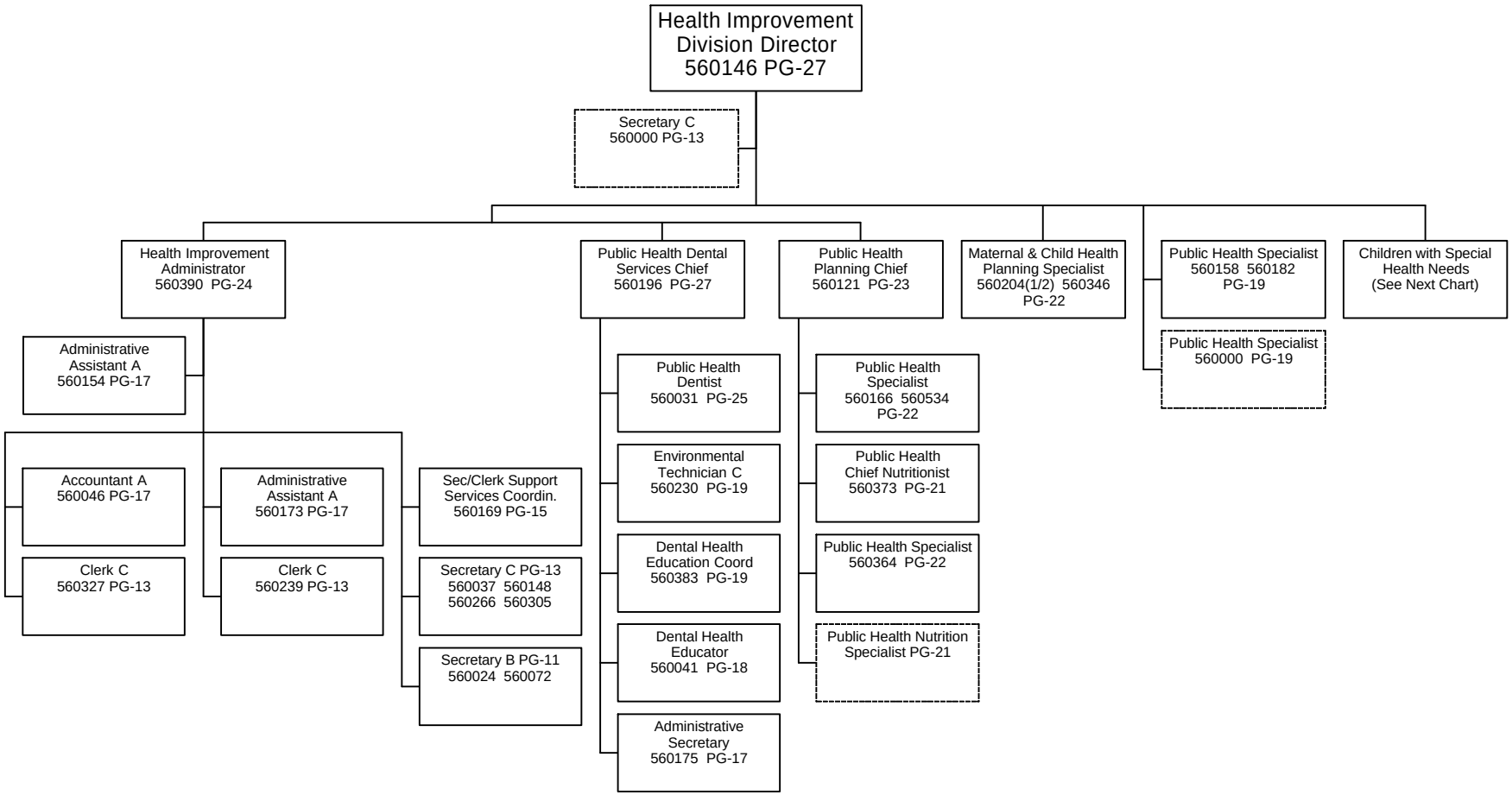
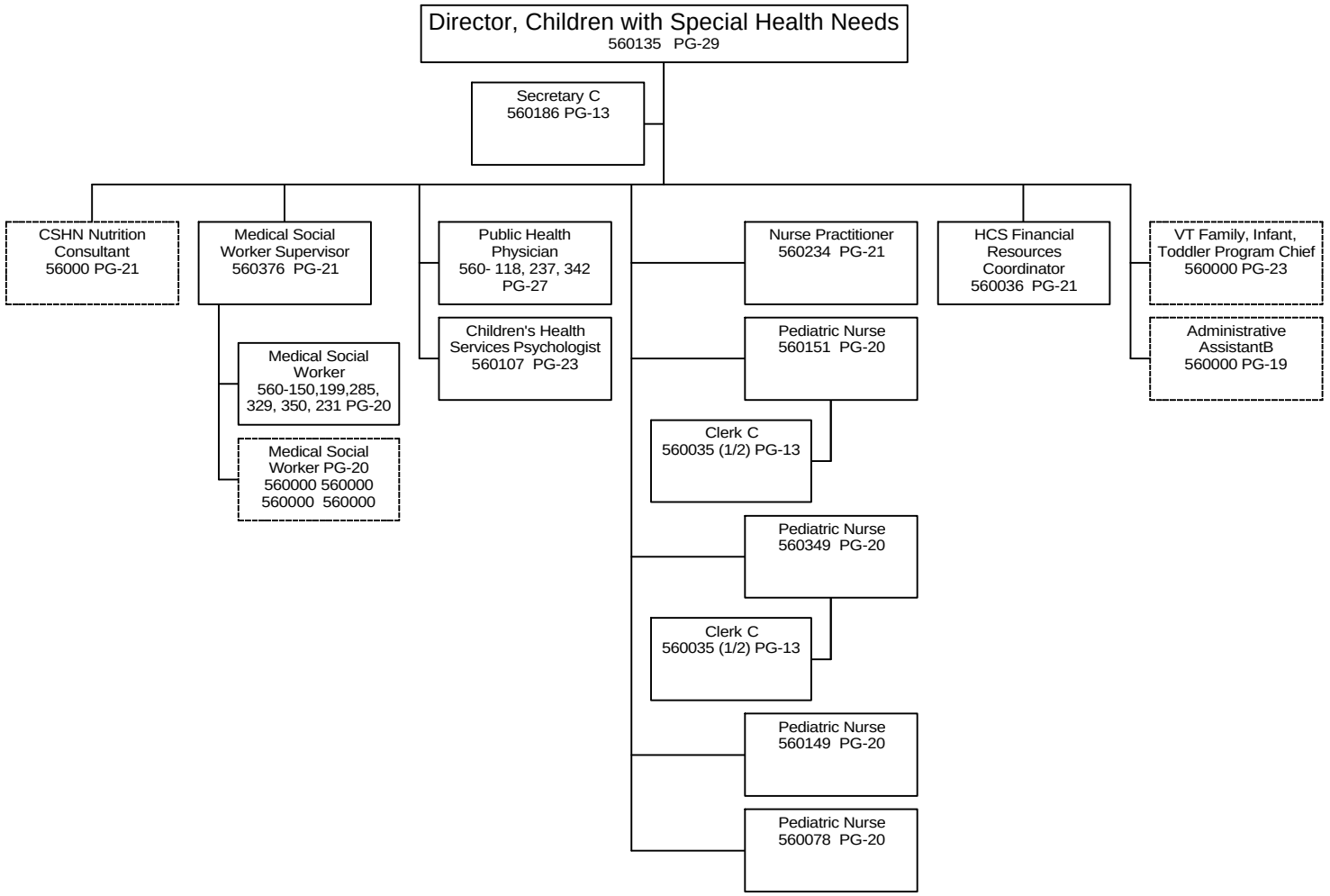
Fiscal Year 2000 Budget
Organization Chart
Vermont Department of Health
Division of Health Improvement



Fiscal Year 2000 Budget
Organization Chart
Vermont Department of Health
Division of Health Improvement - Children with Special Health Needs



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1.5.1.2 Program Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants:
Prenatal and Postnatal Program: *The Healthy Babies System of Care*

The Healthy Babies system of care is an enhanced, comprehensive, family-centered public health program for pregnant and postpartum women and infants up to one year of age who receive Medicaid. (For women and infants not on Medicaid and in need of these services, Title V provides payment.) Healthy Babies is designed as a coalition among obstetrical and pediatric health care providers, public health and home health nurses, Parent Child Centers, and participating families. Case management, counseling and health education, risk reduction intervention, home-based care, group education and other supportive services are bundled together in a Healthy Babies package tailored to meet the individual health needs of each woman.

The program is managed in each of the 12 health districts through the cooperative efforts of local Maternal and Child Health Coalitions. Within each health district, the Department of Health provides the primary administrative functions, including: formal enrollment of women and infants into the program; determination of the level of service for which the individual is eligible, based on medical and psychosocial needs; referral to appropriate community resources; data collection; reports of aggregate information; program evaluation; and oversight of standards for service providers. The program was initiated in four health districts in 1994; four more were added in 1995 and the program has been operating statewide since February 1997, when the remaining four health districts began implementing the program.

Pregnant and postpartum women are referred to this program through local medical providers, service agencies, WIC clinics, EPSDT outreach, school nurses, the statewide toll-free Help Your Baby, Help Yourself hot line, and self referrals. Local MCH Coalitions have further enhanced referral mechanisms for all pregnant women and new parents.

The prenatal component of this program focuses on all pregnant women, with particular emphasis on women identified at high risk for a low birth weight delivery (e.g., history of premature labor, multi-gestation, late entry into prenatal care). The program provides periodic home visits or group encounters that include assessment, education, assurance of access to care, and case management services. Home visiting is conducted by MCH nurses, health outreach

specialists, family support workers and nutritionists and includes a comprehensive, trimester-specific curriculum for prenatal clients. Effective December of 1996, Healthy Babies began reimbursement for perinatal group education for pregnant and postpartum women on Medicaid, thus increasing the accessibility of this education.

Home visits, group encounters, and telephone contacts are continued through the postpartum period. Postnatal service begins with a risk assessment of the mother and infant in the hospital to determine the appropriate time frame for contact after hospital discharge. This time frame is guided by the Maternal Postpartum and/or Newborn Follow-up Algorithm (see 5.3 Other Supporting Documents). Additional services include education about physical status, parenting, health care, breast feeding, exercise, contraception, psychosocial issues, and referral to local services. An integral part of the program is care coordination, which includes referral to appropriate community resources and advocacy in obtaining services. In addition, an emphasis is being placed on including fathers and other family members in the system of care. For example, specific activities are the offering of home visits during the weekend and evening hours and the development of services for fathers, such as the national "Boot Camp" program.

The previous teen system of care has been integrated into the Healthy Babies system of care. Within the Healthy Babies system of care, special priority is given to pregnant and parenting teens. Healthy Babies further enhances the present system of referring a pregnant teen, facilitating early identification and early support in accessing prenatal care and specific psychosocial needs of teens. In addition, the Healthy Babies system of care places an emphasis on parenting skills by connecting teens to home visiting and center-based services offered through parent-child centers. The Healthy Babies data system allows for the evaluation of outcome data specific to teens.

Addison County Parent Child Center - Prevention of Teen Pregnancy Program

Under a contract with the Department of Health, the Addison Parent Child Center provides outreach services to Addison County pregnant teens under age 18, young parents, and their families. Preventive services are also provided to adolescents who are at risk for pregnancy. Comprehensive services for pregnant teens include home visiting, classes and support groups, transportation to medical appointments, resource management, labor support, and support for educational needs. Free pregnancy tests are available to teens with follow-up for both the female

teen and her partner to assure accessibility to contraceptive services (when pregnancy test results are negative) or referral to prenatal and related services (when test results are positive). Free condoms are available at the Parent Child Center. Support groups are provided to both male and female teens and preteens who are considered at high risk of pregnancy, and pregnancy prevention education is provided at the local junior high and high schools. Workshops are conducted for parents of teens on communication techniques about sexuality issues.

Addison County Parent Child Center – The "Dads" Program

The "Dads" program, which is supported by Title X funding, works with young and expectant fathers to develop effective parenting skills. The program offers intensive parenting support and job training, a weekly "Dads" play group which is led by male staff and men in the training program, and outreach services to young and expectant fathers in their homes. In addition, the program provides outreach to young men deemed to be "at-risk" for premature fatherhood through a speakers bureau of young fathers who participate in "teen panels" at area high schools.

Smokers' Assistance Program

All pregnant women receiving WIC services in Vermont are screened to determine their smoking status. Smokers receive a brief cessation message from the WIC certifier and are asked about their intentions to quit smoking while they are pregnant. Women who report that they probably or definitely intend to quit smoking during pregnancy are offered the opportunity to receive proactive support over the telephone from a woman ex-smoker who will call them, typically weekly, to provide encouragement, guidance, and reinforcement for positive changes in their smoking. This service is provided by the University of Vermont (UVM) Office of Health Promotion Research through a contract with the Vermont Department of Health. The program has been expanded to any Vermont provider of prenatal care wishing to refer pregnant women smokers to the telephone support system. The expansion was designed to facilitate the integration of smoking cessation assistance into routine prenatal care by private providers.

Nicotine Patch Project

This project, funded by the Vermont Department of Health with nicotine patches provided by SmithKline Beecham, tests the impact of free nicotine patches with and without proactive telephone peer support to help non-pregnant, Medicaid-eligible women of childbearing age to stop smoking. Women are recruited through flyers and posters distributed to health care, social service, and educational facilities serving lower income women in Chittenden County, Vermont. All women who meet the screening eligibility criteria, return a signed consent form, and complete a baseline telephone assessment are sent free nicotine patches through the mail. Women are randomized to receive or not receive the telephone peer support provided by a woman ex-smoker. Follow-up assessments are conducted by telephone at 3 and 6 months after the baseline assessment to determine smoking status. This project is conducted by the Office of Health Promotion Research at the University of Vermont.

Sudden Infant Death Syndrome (SIDS) Program

The SIDS program offers services to the parents and extended families of SIDS victims, as well as to childcare providers, first responders, hospital staff and law enforcement officials. Through home visits, specially trained public health nurses provide information, support, grief counseling, linkage to support systems and ongoing follow-up and education as needed. This program is closely linked with the Chief Medical Examiner's Office to assure timely home visits as well as the accurate and respectful collection of vital information that contributes to the ongoing search for risk factors associated with SIDS. Community education efforts about SIDS and the Back to Sleep campaign include ongoing training of police officers, local training for first responders and other professionals, and presentations for the general public. An extensive lending library of written materials and videos is available to the public. Planning is underway for an expanded back to sleep campaign to further reduce the risk of SIDS statewide.

Comprehensive Obstetrical Services

This program, administered under contract by the University Associates in Obstetrics and Gynecology in Burlington, provides comprehensive maternity care to women in northwestern Vermont. Services include clinical care and risk assessment, WIC nutrition services, nursing assessment and health education, social and support services, and postpartum and family planning

services through a multi disciplinary health care team. Uninsured women have traditionally been the predominant service users, however, the clinic is open to all women. A public health nurse from the Health Department's Burlington District Office is part of the coordination team of physicians, social workers, nutritionists and nurses. The public health nurse assists pregnant women to enroll in WIC and in the Healthy Babies system of care to assure a cohesive plan of care between home visitors and clinic providers.

Family Planning Program

Family planning services in Vermont are organized to promote awareness of and ensure access to reproductive health services. Services include: medical services, including physical exams, screening for cancer and sexually transmitted diseases, contraceptive methods and pregnancy testing; education and counseling about reproductive health, breast self-exam, STD/HIV risk reduction, pregnancy and infertility; and community education programs such as mother-daughter seminars and school-based education.

Services are provided via contract from the VDH Division of Health Improvement to Planned Parenthood of Northern New England (PPNNE). Services are offered at 12 PPNNE sites statewide. Family planning services are funded by federal Title X and Social Service Block grant and state general funds. Medicaid funds are the most significant revenue source for family planning. All services are available on a sliding fee schedule for those with incomes up to 200 percent of the poverty level, and no one is turned away because of an inability to pay.

Services are targeted to women of child bearing age, particularly those of low income and under age 25. Services to men are also available, and young men are encouraged to participate in counseling and education with their partners. A recent grant from the Office of Population Affairs will test methods for increasing participation by men (ages 18-24) in family planning.

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) has published rules for all Managed Care Organizations licensed to operate in the State. Included in these rules is a provision to allow women up to two covered out-of-plan visits per year (and needed follow-up) for gynecological care. The Vermont Medicaid and Vermont Health Access Plan (VHAP) programs provide payment for family planning on a fee-for-service basis from the provider of choice. This may be the Managed Care Organization,

PPNNE or another provider.

Genetic Services

Genetic services in Vermont are provided through a VDH contract with Children's Health Care Service at Fletcher Allen Health Care, which operates the Vermont Regional Genetics Center. Services include genetic counseling, evaluation, diagnosis, and treatment of genetic conditions; public information programs about teratogens, including a pregnancy risk information toll-free hotline; and technical assistance and consultation to the Department of Health. Services are available statewide. Clinic services are provided to individuals and families with known or suspected genetic conditions as well as to those who are at risk of genetic conditions. Public information is directed at pregnant women, their families and friends, and health care providers. Services are funded by Title V, including federal, state match, and state overmatch dollars, as well as patient fees. The clinic seeks reimbursement for services; however, individuals are served regardless of ability to pay. The pediatric geneticist collaborates closely with the VDH Children with Special Health Needs.

Newborn Screening Program

Genetic screening of newborns has been performed for many years through the Vermont Newborn Screening Program. In 1996, however, the screening was formalized through the Vermont Legislative Committee on Administrative Rules by their unanimous approval of a Vermont Department of Health regulation for the screening of all infants born in Vermont. The rule became effective February 4, 1996. The diseases and conditions for which all newborns are tested under this regulation are: phenylketonuria, galactosemia, homocystinuria, maple syrup urine disease, hypothyroidism, hemoglobinopathies, and biotinidase deficiency. After being informed of the reasons for the screening, the parents, guardians, or custodians of the newborn may refuse in writing to have the tests performed, and any written objection must be sent to the Vermont Newborn Screening Program at the Department of Health. The refusal rate is very low: only 34 of the 6,213 infants born in 1999 had parents who refused to allow the screening tests.

The Vermont Newborn Screening Program continues to assist hospitals, health care

providers and parents, and assures that the program operates according to current standards of practice, including quality assurance standards. Program operations include program development, sample handling, maintenance of records, communication among all parties for failed screening, and professional education services. Newborn screening services are provided through contracts with Children's Health Care Service, Fletcher Allen Health Care (Burlington, VT) and the University of Massachusetts Medical Center (Worcester, MA). The contracts for newborn screening are under the administrative auspices of the Division of Health Improvement in the Department of Health.

Program activities are supported by fees charged to hospitals, physicians, or Medicaid. Fees are charged for screening, although the service is provided regardless of ability to pay. Follow-up services for a child with a specified conditions are provided through the CSHN programs. Families share in the after-insurance costs based upon income and family size.

Refugee Health

The health evaluation for newly arriving refugee families includes screening for tuberculosis, hepatitis B, syphilis, ova and parasites. Health screenings take place within 60 days of arrival in Vermont and are conducted by the Community Health Center (in Burlington) and numerous private medical providers. The role of VDH is to identify and support providers who treat refugee clients, increase awareness of refugee-specific health needs, and ensure timely screening and referral. The Refugee Health Coordinator and Burlington District Office staff work closely with the Vermont Refugee Resettlement Program, the Minority Health Program, and private providers to assure that care is available, accessible, and culturally appropriate. Interpreter services are arranged when necessary. The Refugee Health Coordinator participates in a multi-agency task force that sets standards for training and providing interpreter services. One of the goals of the task force is to educate providers about their roles and responsibilities in providing culturally and linguistically appropriate services. Pregnant and parenting refugee women are routinely offered assistance in accessing EPSDT, the Healthy Babies system of care, and other MCH services; interpreters are used to ensure that refugee women fully understand these benefits.

Perinatal Program

The Vermont Department of Health contracts with the Vermont Regional Perinatal Program at the University of Vermont in Burlington to provide educational and professional support to medical providers who treat pregnant women and neonates ultimately requiring high risk care. Services include professional education, transport conferences, technical assistance, and evaluation conferences to review specific cases. Case review and transport conferences are held with six participating Vermont hospitals. Activities are funded by Title V, including federal, state match, and state overmatch dollars, and fees for service as charged to health care facilities.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

WIC is a nutrition and education program benefiting infants, children under age five, and pregnant, postpartum and breastfeeding women with low to moderate income levels. This program provides supplemental foods and nutrition counseling as an adjunct to health care. Enrolled participants receive weekly home delivery of foods, tailored to their particular needs and eligibility factors, through contracts with local vendors. Nutrition education is offered at least twice during the client's certification period. Individuals with specific nutrition-related concerns receive additional nutrition education contacts from nutritionists. Programs such as the EPSDT Program, the Smoking Assistance Program, and the Childhood Lead Poisoning Prevention Program are integrated with WIC services. The Vermont Department of Health uses a joint WIC/Medicaid application form that automatically assesses and identifies Medicaid eligible clients.

Office of Women's Health

The VDH has been undergoing a two year process to identify women's health needs in Vermont and link the efforts and resources of a variety of national and local organizations working toward improving different aspects of women's health. A formal needs assessment is nearing completion; this assessment has included structured interviews with over forty women's health professionals across the state, seven focus groups with women of all ages, and an examination of existing quantitative data on a variety of women's health issues. Plans are in place to continue women's health efforts beyond this assessment phase: the Bistate (VT/NH) Primary Care Association was recently invited by HRSA to apply for two years of funding to convene a statewide coalition to

create a comprehensive plan to improve women's health and access to care in the state of Vermont. The Primary Care Association worked closely with VDH in applying for these funds, and having now received them, the two organizations are expected to work closely together to apply the results of the two-year needs assessment process to multi-agency planning for comprehensive women's health in Vermont. Vermont was the only state to receive such funds.

Office of Minority Health

The Office of Minority Health provides cultural support services to all VDH programs. Specific to Maternal and Child Health, the VOMH is charged with increasing and strengthening the cultural competency of MCH services, staff, and programs. The VOMH provides the on-going Cultural Competency training for all MCH staff, including cross cultural supervision/management and introductory level training sessions. The VOMH has worked closely with MCH programs to increase and strengthen services to lessen the health disparities facing Vermont's minority populations. Recent special support activities include the development of the Alcohol and Drug Abuse Program's Rite of Passage Initiative, the implementation of a DHHS-OMH grant to address disparities in cancer, diabetes, and heart disease within the Lao and American Indian communities through the strengthening of intergenerational relationships, and the increase of tobacco program activities within the minority and GLBTQ populations. The VOMH is a member of the Interpreter Task Force that coordinates training opportunities for Vermont non-English language interpreters and translators.

Preventive and Primary Care Services for Children:

Immunization Program - Vaccine Purchase and Distribution Program

This program is administered through the Immunization Unit of the Division of Health Surveillance (Epidemiology) at VDH. The program allows for the purchase of vaccines at the federal contract price. Purchased vaccines are available statewide to the medical community, schools, and public health clinics at no charge with the stipulation that clients are not charged for the vaccine. In addition to the actual provision of vaccine, the Immunization Program and district health staff function as technical experts to the local communities regarding vaccines, immunization schedules and histories, risk factors, and contraindications.

Childhood Immunization Registry

The Vermont Department of Health, in collaboration with the Vermont Chapter of the American Academy of Pediatrics, has moved forward with this effort since the enabling legislation for a registry went into effect in 1998. This legislation allows the Vermont Department of Health to work on a pilot program to set up a database of all newborns each year and follow their immunization records through their 18th birthdays. Once the pilot activities have been completed, the program will be extended throughout the state. When fully implemented, the immunization registry is expected to result in higher immunization levels, less work for child care operators and school personnel, and an easier assessment of current immunization status by health care providers as new patients come into their practices, thus decreasing missed opportunities to bring children up to date with their immunizations. An integrated data system for the registry will be obtained after the completion of field visits to assess the functioning of related data systems in other states.

Childhood Lead Poisoning Prevention Program (CLPPP)

CLPPP provides free blood lead screening for children enrolled in the WIC program. In addition, free lead screening is provided for any child who may not have access to lead screening in their medical home. Lead screenings, using a capillary sampling technique, are conducted by specially trained staff in the 12 districts of the Vermont Department of Health during WIC clinics. Children with elevated lead levels are referred to their primary care providers. The Vermont Department of Health has been working with managed care organizations and the Vermont Chapter of the American Academy of Pediatrics to have blood lead screening done in the private sector. Public health nurses provide training to private provider offices in the capillary sampling technique. In addition to assuring proper medical management of children with elevated lead levels, VDH provides an environmental assessment of a child's home and day care if the child is severely poisoned ($\geq$ 20 micrograms/deciliter) or has persistent levels of 15-19 micrograms/deciliter. In owner-occupied housing, VDH works with parents to develop a plan to make their home safe. The VDH has funding from the federal Environmental Protection Agency for its lead abatement licensing activities. The CLPPP conducts education campaigns and community presentations.

Lead-Based Paint Hazard Reduction Program

This program is funded by a U.S. Department of Housing and Urban Development (HUD) grant. Its purpose is to reduce lead hazards in housing throughout the state. Families with children with elevated blood lead levels receive priority for funding. Since the program began in 1994, lead hazard reduction work has been completed in over 740 housing units.

Early Periodic Screening and Diagnostic Testing (EPSDT) Program

The EPSDT Program operates under an interagency agreement with the Department of Social Welfare, the state Medicaid agency. Services are provided to low income children in accordance with the EPSDT requirements and include: education on preventive health care and age-appropriate health screening; assistance with scheduling medical, dental, and other health-related appointments; assistance in locating medical and dental providers; provision of information on other available health services, as well as referral to available and appropriate community resources; and targeted follow-up to assure that appropriate screening, follow-up and treatment are obtained. Vulnerable children, such as those in foster care and children of migrant workers, are the highest priority for EPSDT outreach. The Fostering Healthy Families program is a component of EPSDT which provides special assistance to children in state custody to ensure they are up-to-date with preventive health care. Another important component of EPSDT is the Kids in Safety Seats (KISS) Program. The KISS program trains parents in the proper use of car seats and provides them with vouchers for free or $10 car seats from participating grocery stores.

EPSDT School Health Access Program

This program is designed to improve access to health services for school-aged children and adolescents. By expanding the Department of Health's Medicaid/EPSDT capacity, this program ensures that children receiving Medicaid get appropriate health services and that their full learning potential is not threatened by poor health. By financing certain school health activities with federal Medicaid dollars and non Federal match, local money is freed up to reinvest in health and other human services that enhance the well being of children and families in communities. The program is administered through contracts between VDH and local governing entities called

school supervisory unions. The joint contract sets up a collaborative planning process and best practices approach for the distribution of the reinvestment funds. A committee consisting of school personnel, VDH district personnel, and community members meet to review local data (e.g., the Youth Risk Behavior Survey results, Healthy Vermonter 2000 data) and needs. Once this review is complete, intervention strategies are determined by the committee and prioritized to meet the expected reinvestment funds available. In FFY01, the program will generate over $2 million with 90% of the school supervisory unions participating.

CISS: Health Systems Development in Child Care Grant

A Community Integrated Service Systems (CISS) grant funds a public health nurse specialist to focus on the health needs of children in child care. The Health Systems Development in Child Care grant program, "Healthy Child Care Vermont," was developed to make health and child care a focal point in systems development work at the state level and to meet the health training and consultation needs of child care providers. This project is currently being piloted in the Bennington, Rutland, and St. Johnsbury districts. Plans are being made for expanding the program statewide by Fall, 2000. The grant also expands the involvement of the Division of Community Public Health within the state Early Childhood Work Group.

CISS: Community Organization Grant

Another Community Integrated Service Systems (CISS) grant, the Community Organization grant, targets systems problems in developing a state-wide approach and the capacity to deliver child health supervision that is consistent with the current emphasis on health promotion and the prevention of psychosocial morbidity, in a time of fiscal constraint and health care system change. The goals of the project are to create a clinically useful, Vermont-specific model for comprehensive child health supervision and promotion and to effectively implement and disseminate the new child health model in Vermont's changing health care system, with particular attention to ensuring adequate referral and follow-up systems at the community level. The cornerstone for this project, Vermont's updated "Health Screening Recommendations for Children and Adolescents" was distributed to all Vermont primary care providers and school nurses in January 1999.

Children's UPstream Service (CUPS)

As part of the federal Center for Mental Health Services, Vermont received a Services Initiatve grant in 1997 to support the Children's UPstream Services (CUPS) program. CUPS is a 5-year project designed to support and preserve families of young children who are experiencing, or are at risk of experiencing, severe emotional disturbance (SED). By ensuring access to behavioral health and other community-based services, the program aims to meet the needs of children and families and to build on their strengths. Through CUPS, regional interagency teams, including mental heath providers, offer behavioral health treatment and consultation for the early childhood system of care and for families with young children aged 0-6. Grant support is expected to strengthen local interagency coordination and case review across the systems of care for early childhood and school-aged children and expand needed services statewide. Other key services include crisis outreach, intensive home-based services, respite care, intensive case management, individualized or wraparound services and training. The Director of the Division of Community Public Health is on the state consulting team for CUPS.

Nutrition Services Program (Non WIC and Non CSHN)

School Health: During FY99, efforts to incorporate nutrition in Comprehensive School Health Programs continued. The interagency committee, which included a VSH nutritionist, completed the Department of Education's Comprehensive School Health (CSH) Guidelines. This document links the Vermont Framework of Standards and Learning Opportunities to health education curriculum. In addition, participation continued in the planning, implementation, and evaluation of the School Development Institute, a three-credit graduate course for educators on developing standard-based health units. Over 35 educators attended. A workshop on resources for teaching nutrition as part of standard-based education was implemented. The manual linking the CSH Nutrition Guidelines to Standards, lesson plans and activities was revised and distributed to course participants. These, as well as other nutrition education curricula and resources continue to be distributed to educators as requested.

The nutritionist continued participation in the Department of Education's Comprehensive School Health Institute, a two part, three day training for school teams based on CDC's

Coordinated School Health Model. Teams develop action plans for implementing health programs in their schools. During this past fiscal year, in addition to participating in the planning, implementation, and follow up, the nutritionist designed a program evaluation. The results of the evaluation were utilized to plan this year's conference.

In addition, the nutritionist, as part of the National Health Education Assessment Project, developed middle and high school nutrition and physical activity assessment tools for use in assessing health education. She also participated in the founding board of a non-profit organization dedicated to school health education and to training educators.

Another collaborative school health initiative involved convening a group of interested parties from the Department of Education, the Health Department, and a pediatric allergist to discuss management of severe food allergies in the school setting. From this meeting, an interactive TV training on severe food allergies was planned and implemented for school nurses. In addition, school allergy resources were purchased for the Vermont School Health Education Resource Centers and ongoing technical assistance has been provided to schools.

Nutrition: Early Childhood Education: During FY99, the nutritionist was invited to participate in the "Healthy Childcare Vermont" Advisory Committee. This project is funded by MCHB; its goal is to improve health and safety in Vermont's childcare programs. A nutrition subcommittee was formed and a plan developed to draft several nutrition "tool kits" or training packages to use for child care provider training. In addition, nutrition education resources and yearly trainings for Child and Adult Health Care Program sponsors continue to be provided.

Children's Comprehensive Dental Health Program

Dental Health Services provides dental consultation to the Medicaid/Dr. Dynasaur program. This involves determining prior authorizations on several procedures, including orthodontics. During the 1999 eligibility period, approximately 66,000 children were enrolled in the Medicaid/Dr. Dynasaur program. Dental Health Services collects data and makes recommendations to Medicaid in order to ensure access to dental care for patients who are eligible for state/federally funded programs. Data files are maintained on all prior authorizations submitted, and data are analyzed to determine access to care issues. Medicaid matching funds are used for the

Medicaid/Dr. Dynasaur program.

A coalition, formed in 1996, continues to coordinate Baby Bottle Tooth Decay (BBTD) prevention efforts among family practitioners, pediatricians, primary care providers, dentists, dental hygienists, VDH Dental Health Services, and district office staff. A fee under Medicaid has been established to reimburse dentists for oral hygiene instruction for the parents of children under age 5. The coalition is working to increase the number of practitioners prescribing fluoride supplements (when necessary) and educating parents about their benefits. Health care providers are encouraged to determine the fluoride level of their patient's primary water supply before prescribing fluoride supplements.

Fluoride Program

Community fluoridation activities through VDH involve both promotion and technical assistance/surveillance activities, which include monitoring fluoride levels. Promotion efforts continue to increase the number of Vermonters receiving fluoridated water. Forty-three communities with 29 water systems are currently fluoridated. The school-based fluoride mouth rinse program currently serves 20,000 students in 166 schools. VDH provides the school programs with supplies, training, materials and educational resources. Fluoride services are funded by the Preventive Health and Health Services Block Grant and state general funds.

Emergency Medical Services - Children (EMS-C)

The VDH Office of Emergency Medical Services and Injury Prevention has received three EMS-C grants since 1989 to improve the capacity of the emergency medical service system to care for children by striving to improve all components of Vermont's EMS system. The current State Partnership Grant has three objectives: 1) Represent pediatric emergency care issues in all aspects of the emergency medical service system; 2) Assist with the delivery of the Family Practice Resuscitation Project to fifty family practice offices and 3) Develop a prehospital data collection plan for the Vermont Emergency Medical Service System. The project continues to provide technical assistance and educational programs to EMS organizations, as well as participate in a variety of activities such as the Vermont Child Fatality Review Committee and the Injury Prevention Task Force.

Child Fatality Review Committee

The Child Fatality Review Committee (CFRC) is a multi-disciplinary team that reviews the deaths of all resident children, ages 0-18, with particular attention to child protection/neglect issues and systems issues that may need to be addressed in order to prevent child and adolescent fatalities. The Director of CSHN and the MCH Planning Specialist serve on the Committee to link the efforts of the Committee to ongoing Vermont Department of Health efforts concerning infant mortality, childhood injury, and other causes of death to children and adolescents. The Division of Health Improvement continues to develop a data collection system and database designed to systematically assess factors that may be related to childhood deaths, such as Sudden Infant Death Syndrome (SIDS), child and adolescent deaths from injury, and youth deaths from suicide. The Child Fatality Review Committee analyzes systems issues that may impact child fatality rates and coordinates with VDH staff for planning MCH programs and activities.

RWJ Making the Grade

Vermont has been granted a one year extension on it's Making the Grade grant program. There is approximately 200,000 in unspent grant funds available to communities which are interested in establishing new school-based health centers. At the present time we have three school-based health centers in Vermont. These are located at the South Royalton School, the Newton School in South Strafford and the Burr and Burton Academy in Manchester. Since December, 1999, small planning grants ($3,000 to $10,000) have been given to three other communities to do a needs assessment survey to determine whether there is community support for a school based health center at their schools. (The three schools are Missisquoi Valley Union High School, the Rivendell Union School District, and the Burlington School District.) The Vermont Making the Grade Project Director and Coordinator work in the Planning Division in the Agency of Human Services in Waterbury, Vermont.

State Incentive Cooperative Agreement

The State Incentive Cooperative Agreement (SICA) is a component of the National Youth Substance Abuse Initiative, which was established to address a national pattern of increasing

youth substance use. Vermont is one of five states to receive a SICA grant from The Center for Substance Abuse Prevention to reduce teen use of alcohol, tobacco, marijuana and other drugs. The grant is based on the premise that underage substance use and adult substance abuse is a community issue, and that both adults and youth need to be actively involved in the solution. Program activities include: Organizing the Vermont Coalition for the Prevention of Substance Abuse to develop a comprehensive strategy for addressing alcohol, tobacco and other drug issues based on well-researched and effective substance abuse prevention efforts; involving Vermonters in learning what works for communities, families, schools and peer groups in the prevention of substance use; assisting communities in putting these approaches into action through training and funding opportunities; and evaluating the progress of community grantees. This grant is designed to fund communities that develop comprehensive strategies based on an assessment of what the community and its families, schools, and youth need in order to prevent substance use. These strategies must be based on models that have been proven to show results.

Vermont Department of Health 1-5 Program

1-5 is a home visiting program for "at-risk" children ages 1 through 5 who are enrolled in Medicaid. Among other eligibility criteria, families must have a child who is at risk for unnecessary and avoidable medical interventions and who is not receiving case management services through another program; in addition, the child must be referred to the program by a primary care provider. While the Vermont Department of Health coordinates the program, direct services are provided by RNs or masters level social workers employed by the area home health agency. The goals of the program are to reduce: inappropriate use of ER/MD visits needing case management; unnecessary hospitalizations; avoidable medical complications; failure to thrive; unmanaged chronic medical conditions; unmanaged neurological or sensory disorders; or observable and measurable delay in one or more of the following developmental areas: cognitive, physical (including hearing and visual), communication, social, emotional, or adaptive. The program was implemented across the state on July 1, 1998.

Vermont Kids Against Tobacco

Vermont Kids Against Tobacco (VKAT) is a peer leadership program at VDH that provides

training, technical assistance and funding for middle school aged youth programs. This assistance enables youth to educate their peers and younger students about tobacco and to promote a tobacco-free lifestyle in their schools and communities. In addition, the program is designed to provide an opportunity for Vermont youth to act as leaders in their communities and to raise awareness about tobacco advertising and merchandising targeted at young people.

Vermont Department of Health Diabetes Control Program

In January 1999, the Diabetes Control Program at VDH and the Diabetes Awareness Wellness Network (DAWN) issued "Recommendations for Management of Diabetes for Children at School." The manual provides guidance to school staff on management of diabetes in the school setting and promotes the full integration of students with diabetes in school activities. Parents have identified that they would like this resource to be given to every family upon diagnosis of diabetes in a child. The publication is under review for editing and addition of sections for preschoolers.

Gestational diabetes has been included in the "Recommendations for Management of Diabetes in Vermont, 2nd edition" published in January of 2000. This manual is distributed to all physicians, nurse practitioners, major health care institutional providers and others who requested the manual. The recommendations of the manual have been adopted as the standards of diabetic care in Vermont. Data related to gestational diabetes is being published in "Diabetes in Vermont: A Review of the Data: 1999-2000."

Vermont Department of Health Injury Prevention Program

Injuries are a significant cause of death and disability in Vermont. To address this serious public health issue, the Vermont Department of Health applied for and was awarded a five year grant from CDC for core injury program development. A program coordinator was hired in February, 2000 and has formed an injury prevention advisory committee. The program's purpose is to analyze Vermont's injury data, identify priority areas for action and to develop a strategic plan for each priority area. In particular, a comprehensive plan for suicide prevention in all ages will be developed.

The injury prevention program coordinator participates n the Northeast Injury Prevention

Network, a volunteer public health organization dedicated to the collaboration and sharing of ideas among eight state health department injury prevention programs. The network has its origins in the New England Network to Prevent Childhood Injuries which was begun in 1985 as a partnership among state Maternal and Child Health Directors, state injury prevention program directors and staff of the Education Development Center in Newton, Massachusetts. Vermont is presently exploring ways to coordinate and collaborate between the Injury Prevention Coordinator and the MCH staff and programs.

Primary Care Program

The Bureau of Primary Health Care provides funding for the Office of Primary Care and Rural Health (OPC/RH) to advocate for and coordinate state primary care activities that promote the development and provision of innovative and progressive primary care services for the underserved. The Vermont Cooperative agreement aids in planning for primary care resources, the development and administration of medical and dental loan repayment programs, the provision of opportunities for community based providers of primary care and specialty care to work together on state and regional issues, and the provision of training and technical assistance to community based organizations. In addition, the OPC/RH is responsible for analysis of provider coverage and application for appropriate Health Professional Shortage Area and Medically Underserved Area designations.

The Primary Care Steering Committee provides leadership in monitoring and assessing health policy development and its impact on primary and specialty care programs as well as mental health and oral health programs that serve traditionally underserved and vulnerable populations. A chief goal of the PCSC is to identify communities and populations within the state that lack access to preventive and primary care services and to develop strategies to improve access and quality of care for these Vermonters. To do this, the Committee expands communication and collaboration among existing provider agencies and community-based organizations by encouraging networking and offering technical assistance and supportive strategic planning within the targeted communities. The program also works with local providers to ensure that they have sufficient support systems in place to provide the caliber of care needed and the resources to offer culturally appropriate linkages and educational opportunities for their

patients.

System of Care for Children with Special Health Care Needs:

Vermont's Children with Special Health Needs (CSHN) program provides family-centered, community-based, coordinated services for Vermont children with special health needs and their families, through direct services (clinics), care coordination, financial assistance, family support, and system-building activities.

PYRAMID LEVEL: DIRECT SERVICES

CSHN Clinics

CSHN organizes and manages a statewide network of multidisciplinary clinics for children with certain chronic conditions. These clinics include Orthopedics (General Orthopedics, Spina Bifida, Muscular Dystrophy,, and Hand), Child Development, Seating (assessment, prescription and fitting of mobility and positioning equipment), Cleft Palate/Craniofacial, Hemophilia, Cystic Fibrosis, Cardiology, Juvenile Rheumatoid Arthritis, Epilepsy, NICU High-Risk Developmental Follow-up, Interdisciplinary Leadership Education for Health Professionals (ILEHP, a UAP-LEND project), Community Clinics, and Feeding Team. Clinics are attended by CSHN staff and by contracted specialists. Clinics are offered at no charge to families, although private insurance or Medicaid may be billed. Services, including certain diagnostic services and treatment, which are prescribed or authorized through clinics are also covered but may be subject to a Cost Share deductible (see below). Services are available to Vermont-resident children who have a covered condition, birth to age 21 years. Lifelong services are available for individuals who have cystic fibrosis.

CSHN has expanded its formal and informal collaboration with Dartmouth Hitchcock Medical Center which, while not in Vermont (it is in Lebanon, NH, just over the Vermont border) is nonetheless viewed as the community hospital for an area of eastern Vermont, and as a tertiary care center for a sizeable region of Vermont. CSHN provides 0.5 FTE support to the coordinator of the Dartmouth Child Development Program that serves many Vermont children, and has begun to hold "Vermont Day" clinics in pediatric orthopedics there. Referrals to specialists at

Dartmouth are facilitated by CSHN care coordination staff and may be covered financially through the Cost Share program (if not private insurance of Medicaid).

Financial Assistance Program

CSHN provides after-insurance funding of medical services when these services have been pre-authorized by CSHN staff and when they fall within the range of services permitted by CSHN guidelines. Since 1993, CSHN has utilized an income-based Cost Share plan in conjunction with its Financial Assistance Program. Under this plan, families with gross incomes above 225% of the Federal Poverty Level (FPL) are expected to meet an annual deductible before CSHN funds are utilized, unless their child is eligible for Medicaid, either through the TEFRA option ("Disabled Children's Home Care Program" or "Katie Beckett Program") or through the October 1998 expansion of the Medicaid/Dr. Dynasaur program for families with incomes up to 300% of FPL. Families with incomes between 225 and 300% FPL who have no other source of insurance may enroll in Vermont's CHIP program. The CSHN Cost Share deductible is waived for children of any income who have Medicaid.

In Vermont, children who are eligible for SSI are automatically eligible for Medicaid. Medicaid, because of its EPSDT requirements and because of the state's interpretation of Medicaid intentions, offers the broadest and deepest coverage of health care needs for children, including full implementation of services such as Personal Care Services (attendant care). Many children with SSI are also enrolled in CSHN programs or in other state agency programs such as Developmental Services.

PYRAMID LEVEL: ENABLING SERVICES

Special Services

Through its Special Services Program, CSHN offers care coordination and access to specialized services for Vermont children who have a condition which CSHN covers but for which no established clinic exists. CSHN pediatric nurses and medical social workers are based in regional offices. Staff are involved in care planning and coordination, including transitions from one care setting to another. Families are referred to CSHN from Medicaid's High-Tech program when it is

first determined that the child will need intensive, home-based medical care. The medical social workers are also members of the regional Part C-IDEA early intervention services teams, Family, Infant and Toddler Project of Vermont.

Respite Care Program

CSHN manages a limited respite care program, whereby families receive annual grants to defray the cost of hiring respite care providers. Allocations to families are based on the skill level of the care needed. Family eligibility is based on enrollment in CSHN, family income and need, and ineligibility for respite care from the Department of Developmental and Mental Health Services.

Parent to Parent of Vermont

CSHN makes a substantial annual grant to Parent to Parent of Vermont to support its statewide network of programs, which include Supporting Parents, outreach to community providers, pre-service and in-service training to medical and early intervention staff and students, continuing education for CSHN staff and community providers, and participation in program and policy design for CSHN. Part of the funding specifically supports the work of three parents as Regional Children's SSI Coordinators, providing outreach information and referral for families whose children have received SSI but are not (or not yet) enrolled in CSHN. The Parent to Parent SSI outreach expansion is supported by CSHN, utilizing state general funds and EPSDT administrative case management match.

In-Home Support Program

Since October 1995, Medicaid has made available Personal Care Services (PCS) for in-home support for children with severe disabilities. CSHN serves as one of several access points providing both referral and assessment for PCS, and the CSHN director is a member of the PCS eligibility determination committee. The committee also authorizes the number of hours-per-week of support that a child may receive. Over 600 children with disabilities now receive PCS.

Nutrition Services

CSHN and Part C-IDEA collaboratively fund a state-level pediatric nutritionist who is developing

and expanding the capacity of community-based nutritionists to provide consultation and treatment to children with special health needs. Community-based nutritionists have been recruited to receive inservice training in nutritional care of children with chronic conditions, with the training organized and provided by the state CSHN nutritionist. In turn, children are referred to the trained nutritionists for evaluation. The state CSHN nutritionist reviews each evaluation, assists in the development of the plan of care, and provides technical assistance in the treatment. At this writing, nutrition services are not well covered by insurance and CSHN is often the payer of last resort. However, CSHN is working on a new funding arrangement with Medicaid for these services. CSHN also manages a nutritional formula program for children needing special formulas or "nutriceutical" treatment of their chronic condition. The 1998 legislature mandated insurance coverage of special formulas and foods required in the treatment of metabolic conditions for which the state screens newborns. CSHN developed agreements with the major insurers and Medicaid to function as a clearinghouse for medical foods for children.

Family Support Services

As mentioned above, CSHN provides support to Parent to Parent of Vermont for its support of families, and for its annual Partners in Care family/provider collaboration conference. The respite care program described above is also one of CSHN's Family Support Services.

Family, Infant and, Toddler Project (FITP)

FITP is the statewide early intervention system of care for infants and toddlers with developmental disabilities, funded by Vermont's federal Part C-IDEA grant. FITP is centrally administered through CSHN, but is delivered regionally. Each of the twelve AHS districts has established its own regional planning team, designated a host agency, developed a budget in response to central guidelines and federal mandates, and, within the structure set forth by the Interagency Coordinating Council, developed programs that comply with Part C rules. The FITP director is supervised by the CSHN director. CSHN regional social workers are members of FITP regional core teams (interdisciplinary service teams), smoothing the transition at the child's third birthday and offering some continuity in a child's team composition. When a child is enrolled both in FITP and CSHN, CSHN stands just ahead of FITP in the line-up of "payers of

last resort" for authorized services. The CSHN financial unit also handles FITP payments so that families experience a "seamless" funding system.

Please also refer to the section *Children receive regular ongoing care within the medical home* which is described in more detail under the PYRAMID LEVEL: INFRASTRUCTURE, below.

PYRAMID LEVEL: POPULATION-BASED SERVICES

Newborn Screening Follow-up

In follow-up to the screening of all Vermont newborns for metabolic, thyroid, and hemoglobin disorders, CSHN provides clinic-based and care coordination services for children with these conditions. Follow up of positive or inadequate screens is performed through a Health Department contract to the Vermont Regional Genetics Center and is monitored by the Newborn Screening Advisory Committee, of which the CSHN director is a member.

Please also refer to the section, *Children are screened early and continuously for special health care needs* in the PYRAMID LEVEL: INFRASTRUCTURE section below, for a description of newborn hearing screening capacity development.

PYRAMID LEVEL: INFRASTRUCTURE-SYSTEM BUILDING ACTIVITIES

This section is organized according to the six CSHCN systems outcomes articulated by MCHB/CSHCN and used as the basis for the MCHB-funded Measuring and Monitoring Project (Utah State University).

"Children receive regular ongoing care within the medical home"

CSHN has helped to support and participate in two projects enhancing the ability of primary care to provided a medical home model practice, the MCHB-funded Rural Medical Home Improvement Project and the originally SSDI – and now Healthy Tomorrows Partnerships – funded "Whatever it Takes" project. In addition, CSHN has been a vocal participant in the development of the new Medicaid primary care case management model, "PC Plus", which was initially intended to enroll SSI recipients into Medicaid managed care, and has

now expanded to include nearly all Medicaid "eligibles". (This discussion also cross references with PYRAMID LEVEL: ENABLING SERVICES, above.)

"Families have adequate insurance to pay for needed services"

With the expansion of Dr. Dynasaur (Medicaid and CHIP) to 300%FPL, Vermont continues to improve the percentage of children who have a source of adequate health care coverage. Until early 2000, Medicaid enrolled children, including CSHN, were enrolled into HMO-model managed care plans. CSHN had established written agreements with the Medicaid MCO's to delineate responsibilities and to streamline access and authorization processes for families. As a payer of last resort for many medical services needed by CSHN, CSHN has developed and strengthened its internal financial processes for helping families to apply for Medicaid, understand their own insurances, and pursue benefits to which they are entitled. In the gap, CSHN has continued to be a payer. For children enrolled in the Part C Early Intervention system (Family, Infant, Toddler Project, FITP) which is also administered within CSHN, the payer of last resort function should be seamless and efficient.

Because Medicaid is the major insurer for Vermont CSHN, collaboration between Medicaid and CSHN is particularly helpful. Medicaid has delegated to the CSHN director the responsibility for determination of the medical necessity and authorization of continuation of services for OT, PT, and speech services for children after they have received then for a year. CSHN also reviews and facilitates the ordering of wheelchairs and other seating and positioning equipment, as well as the coordination of insurance and Medicaid coverage for the equipment. In addition, the CSHN director is one of three interagency staff who review children's applications for Personal Care Attendant Services (a fee-for-service Medicaid support). This role afford, on an individual basis, the opportunity to review a child's care plan and the resources to support the plan; often, additional resources can be suggested.

At the same time, the collaboration with Medicaid in the prior authorization of individual services also is the basis for systems-level solutions to coverage issues that arise with individual children. During the writing of this report, for example, CSHN hosted a working group from Medicaid, Part C, Education, Developmental Services, and Aging and Disabilities, to look at the gaps and overlaps in coverage of assistive technology for children. CSHN is able to identify and

define health care coverage issues for CSHN, and, in a small state, advocate informally and formally for solutions.

Finally, through its more flexible, discretionary ability to fund services, CSHN makes available access to pediatric specialty providers (particularly OT, PT and nutrition) who are not part of the Medicaid provider network (Medicaid does not enroll providers in individual practice in these disciplines). CSHN continues to advocate with Medicaid for an arrangement that will address this systems issue; we have recommended that CSHN itself be recognized as a provider agency of these services. A similar arrangement has been made for CSHN to be a vendor of metabolic food and formulas.

"Children are screened early and continuously for special health care needs"

CSHN is increasing efforts to encourage universal newborn hearing screening, with hospital nursery screening as the starting point in a system of assurance. During the reporting year (FFY99) and presently, Vermont does not have a system for assuring that all newborns are screened for congenital hearing loss while in the hospital nurseries. However, in response to the guidance of CSHN's Advisory Council on hearing issues, CSHN partnered with the Vermont Association of Hospitals and Health Systems (VAHHS) and with Fletcher Allen Health Care (FAHC) to establish a statewide network of hearing screening clinics, the Hearing Outreach Project (HOP). In 1999, the legislature required VDH to establish a study commission to determine and report upon what it would take to implement universal newborn hearing screening in Vermont. The CSHN director chaired this commission. The Executive Summary of this report is contained in the appendix. The report recommended that hospital nurseries be urged to begin UNHS, that VDH could be a source of technical assistance, that HOP evolve from a network of clinics performing targeted hearing screening for young children to a statewide follow up and assurance system for UNHS. These goals could be implemented without any state mandate to do so, following the model of Vermont's newborn metabolic (bloodspot) screening program. At the time of this writing, HOP has collaborated with four community hospitals to the point of their selecting the screening equipment, and two (one in FFY99) have begun screening all newborns. It seems very likely that other hospitals will participate in the near future. CSHN is positioned to continue to support the effort with technical assistance and follow up from the Hearing Outreach

Project. (this discussion also cross-references with PYRAMID LEVEL: POPULATION-BASED SERVICES, above).

Families are decision makers and satisfied with services

CSHN relies upon and collaborates with Parent to Parent of Vermont and its network of supporting and participating for guidance and input about program quality and direction. Please see section 3.1, Needs Assessment, for a discussion of this aspect of infrastructure and systems building.

Services are organized in ways that families can use them easily

See *Nutrition Services*, in ENABLING SERVICES above, for efforts to strengthen community based nutrition services capacity. In addition, CSHN supports the capacity of community based OT and PT by contracting with the two pediatric therapy provider agencies, considered by their peers to be highly expert in the fields. The contracts support their attendance at CSHN clinics and their availability to community-based therapists for consultation. For example, one of the contractor therapists recently traveled to a rural community to give guidance about the evaluation and treatment of some of the patients of one of the local therapists. FITP, Vermont's Part C IDEA program, also provides statewide inservices on early intervention practices targeted to early intervention providers, including OT, PT and speech therapy (among others).

As nationally, Vermont is experiencing a shortage of home based care providers, including nurses, nurses aides, and personal care attendants. CSHN is working very closely with other departments and programs within the Agency of Human Services, to find and implement strategies to increase the numbers of hours of Personal Care Attendants Services which families are able to fill with attendants with who they are satisfied. By the end of FY2001, there should be a measurable indication of success of the strategy (the percentage of hours allocated which have been utilized).

Beyond the scope of this Title V report, but important to mention, are the efforts to strengthen the community based early intervention system, the Family, Infant , Toddler Project. The central administration of FITP lies organizationally within CSHN, which is also the final

common pathway for the federal Part C grant. Please also see the *Family, Infant and Toddler Project* section in PYRAMID LEVEL: ENABLING SERVICES, above.

CSHN's system building efforts are greatly strengthened by its participation in New England SERVE discussions and collaboration, and in the Association of Maternal and Child Health Programs (AMCHP) and its committees. The CSHN director serves on the AMCHP Policy and Programs committee. Recent New England SERVE facilitated discussions have included such essential topics as newborn screening, and the relationship between CSHN programs and tertiary care centers.

Youth receive services necessary to transition to adulthood

The Department of Social and Rehabilitative Services (SRS) has recognized that some children and youth in foster care have serious special health needs, and that the disruption in their home stability and placement may make them particularly vulnerable. The CSHN director participates on a monthly interagency committee that provides consultation/case reviews to assist the local SRS team in supporting the child. As many of the children are adolescents, often the critical care issues include long term planning for the special health need, particularly as other sources of care, such as education, also have major points if transition at the same time.

CSHN has a written agreement with the Division of Vocational Rehabilitation concerning the mutual referral/acceptance of clients.

CSHN participates both on a case-by-case basis (which informs the system) and an interagency basis, to smooth the transition from pediatric in-home support services such as Personal Care attendant services to other programs which may provide similar supports. These latter programs are Medicaid Home and Community Based Services Waivers within the Department of Developmental and Mental Health services and the Department of Aging and Disability.

1.5.1.3 Other Capacity

Maternal and Child Health staff at the Vermont Department of Health include:

Division of Community Public Health	FTE	Advanced Degrees	# FTEs Outstationed
Division Director	1	BSN, MPH	0
Central Office Program Administration	22	6 Masters level	0
Local Public Health:			
District Directors	12	6 Masters level	all
Public Health Nursing Supervisors	16		all
Public Health Nurses	68	3 Masters level	all
Nutritionists	8.5	4 Masters level	all
Health Outreach Specialists	22		all
Clerical staff	33.5		30
Division of Health Improvement			
Division Director	.50	MD	0
MCH Planning and Evaluation Unit:			
Chief of Public Health Planning	.25	Masters Level	0
Chief of Rural Health and Primary Care	.5	Masters level	0
MCH Planner	1		0
Support staff	.75		0
Nutrition:			
Nutrition Chief	.75	Masters level	0
Minority Health:			
Director of the Office of Minority Health	.25	Masters level	
Dental Health:			
Director	.75	DDS, MPH	0
Public Health Dentist	.25	DDS	0
Health Educators	2		0
Fluoridation Technician	1		0
Support Staff	1		0
CSHN Programs:			
Director	1	MD (pediatrician)	0
Physicians	2.5	MD (pediatricians)	0
Administrators	1		0
Social Workers	9	10 Masters level	6
C.P. Nurse Practitioners	1		0
Psychologist	1	PhD level	0
Nutritionist	1	Masters level	0
Registered Nurses	6	1 Masters level	3
Program Chief	1	Masters level	0
Support staff	13		2

Commissioner of Health

Dr. Jan Carney received an MD from the University of Cincinnati in 1981. Following medical school, Dr. Carney completed a three year Internal Medicine residency at the Medical Center Hospital of Vermont and served as Chief Medical Resident the following year. In 1987, she earned a Master's degree in Public Health (MPH) at Harvard School of Public Health, where her studies concentrated on causes and prevention of chronic diseases, particularly cancer. Dr. Carney was appointed Deputy Commissioner of the Vermont Department of Health in 1988 and Commissioner of Health in 1989. In addition to her public health activities, Dr. Carney is Board Certified in the areas of Internal Medicine and Preventive Medicine and holds an academic appointment at the University of Vermont College of Medicine where she is a Clinical Professor of Medicine.

Division Director of Health Improvement and Director of Maternal Child Health

Donald Swartz received his MD degree from West Virginia University in 1963. He interned at West Virginia University Hospital and then completed a residency in Pediatrics at Children's Hospital in Cincinnati, Ohio in 1966 and served as Chief Resident there until 1967. He was in private practice of pediatrics from 1968 until 1986 and then in private practice of Pediatric Pulmonology until 1999 when he was appointed to his current position. He has directed the Vermont Cystic Fibrosis Program since 1968. He is Board Certified in Pediatrics and in Pediatric Pulmonology, and holds an academic appointment at the University of Vermont College of Medicine where he is a Clinical Professor of Pediatrics.

Division Director of Community Public Health

Patricia Berry earned a BSN from Boston College in 1969 and a Master of Public Health (MPH) degree from Johns Hopkins University, School of Hygiene and Public Health in 1982. In addition to Ms. Berry's eight years of public health nursing experience, she served as Public Health District Director in Vermont from 1978-1981 and as Public Health Planning and Policy Chief for the Vermont Department of Health (VDH) from 1982-1984. She has served in her current position as Director of the Division of Community Public Health at VDH since 1984, providing leadership and oversight of the state's local public health system and the WIC, EPSDT, Healthy Babies and

other MCH programs.

Director of Children with Special Health Needs Programs

Dr. Carol Hassler earned a MD from the University of Pennsylvania in 1976. Her residency in Pediatrics took place (in 1976-1978) at the University of Virginia, and Dr. Hassler held a fellowship in Child Psychiatry at the University of Virginia (1978-1980), where she also served as Chief Resident from 1979 to 1980. She has served as the Director of Vermont's Children with Special Health Needs program since 1995, Director of the Division of Children with Special Health Needs at the Vermont Department of Health from 1990-1995, and Director of Handicapped Children's Services at VDH from 1985-1990. Dr. Hassler also serves as Clinical Associate Professor of Pediatrics at the University of Vermont College of Medicine and as an Attending Physician at the Fletcher Allen Health Care Hospital.

Director of Dental Health

Dr. Roger T. Ivey earned his DDS degree in 1973 from the Medical College of Virginia and a Masters in Public Health in 1982 from the University of Minnesota. Dr. Ivey has over 11 years of clinical dentistry experience in the U.S. Army, the V.A. Hospital in Martinsburg, WV, and has also worked in the Virginia Public Health Department. Since 1992, Dr. Ivey has been the Vermont State Dental Director at the Vermont Department of Health.

Nutrition Chief

Alison Gardner holds a Master of Science degree in Nutrition Science from the University of Vermont and is a registered dietician. She has over fifteen years of public health experience including assessment, planning, implementation and evaluation of nutrition programs. Since 1991, Alison Gardner has been the Public Health Nutrition Chief at the Vermont Department of Health.

MCH Planning Specialist

Sally Kerschner is currently completing a Masters of Science in Nursing at the University of Vermont. She has twenty-five years of experience in maternal and child health and community health nursing. She has worked at the Vermont Department of Health since 1983.

CSHN/Parent to Parent

Through CSHN funding of Parent to Parent of Vermont, CSHN hires 3 parents as Children's SSI Coordinator, providing outreach to Vermont families whose children are eligible for SSI. In addition, seven of the CSHN clinical staff are parents of children with special health needs.

1998 Physician Survey

Please refer also to the discussion in the Needs Assessment, Section 3.1.2.3

Assuring an adequate supply of primary care providers, particularly in the more rural areas of Vermont, requires careful study and continuous attention. The 1998 Physician Survey provides information used to identify medically underserved areas, to monitor trends, and to evaluate the need for recruitment incentive programs. In 1998, there were 1410 physicians providing patient care in Vermont (1374 medical doctors and 36 osteopathic physicians), representing in full-time equivalents (FTEs) full-time providers. Of these, 593 physicians (450.3 FTEs) provided primary care, including 248 in family practice, 183 in general internal medicine, 113 in Pediatrics, and 71 in Obstetrics/Gynecology. Six counties have a severe shortage of primary care physicians (less than 67 physicians per 100,000 population), and only three have an adequate physician-to population ration. Statewide, Vermont has an average of 76.2 full-time equivalent primary care providers per 100,000 population, compared to the recommended average of 78 per 100,000. The situation has improved somewhat in recent years: between 1995 and 1998, a total of 206 physicians began practice in Vermont (76 providing primary care). A Physician Survey for the year 2000 will be administered in at the end of this year with updated numbers available in 2001.

1.5.2 State Agency Coordination

The Vermont Agency of Human Services consists of the Department of Health, Department of Social Welfare, Department of Social and Rehabilitative Services, the Office of Child Support Services, the Department of Developmental and Mental Health Services, the Department of Corrections, the State Economic Opportunity Office, and the Department of Aging and Disabilities. The Department of Health has 12 district offices that serve as local health departments and cover the entire state. The local district offices of the VDH work closely on case

management and service coordination with the local state (such as those listed above) and community offices which provide social, health and welfare services. The local district offices also are developing close ties with the community health centers that provide services in their regions and the AHEC districts. At the state level, the community health centers are part of the Primary Care and Rural Health programs.

Within the Department of Health, close working relationships exist among the divisions of Health Improvement (which includes the CSHN Programs), Community Public Health, Health Surveillance (epidemiology and statistics), Health Protection, and the Alcohol and Drug Abuse Programs. All VDH Division Directors meet at least monthly to coordinate Department of Health activities.

The Vermont State Team for Children, Families, and Individuals

Among the Departments within the Agency of Human Services, a unique collaborative relationship exists through the Vermont State Team for Children, Families, and Individuals. The State Team is a multidisciplinary, statewide collaborative effort comprised of representatives from the various state agencies and departments including Developmental and Mental Health Services, Social and Rehabilitative Services, Welfare, Health, Education, the University of Vermont, parent groups and community coordinating councils. Its mission is to "support the creation and maintenance of effective services for children and families through partnerships with families and communities."

One feature of the State Team that is particularly advantageous for collaborative working relationships throughout the state is the presence and participation of Community Partnership groups from all 12 AHS districts, which closely mirror the health districts. Each of the 12 Community Partnership groups have a liaison member at the monthly State Team meetings. The State Team provides support to the Community Partnerships which coordinate health and human service efforts at the district/community level. In each district, the VDH district director is a key member of the Community Partnership team. The MCH Director and a number of other members of the MCH staff also serve on the State Team. One central focus of the State Team has been to formulate common desired outcomes shared by families, advocates, and service agencies, and to determine specific indicators that will allow progress toward achieving these outcomes to be

tracked by community and state partnerships.

State Team meetings focus on selected outcomes, reviewing interventions and programs that have been proven effective (compiled into a document called "What Works") and activities that are taking place in Vermont to influence the selected outcomes. The Agency of Human Services collaborates with the VDH School EPSDT Health Access program to produce "What Works" documents, to summarize key findings on selected outcomes, and to assist in the planning process for making further progress in Vermont with respect to each outcome. AHS also publishes Community Profiles for each of the School Supervisory Unions in the State. These profiles reflect the outcomes and indicators chosen by the State Team, allow for tracking of progress on outcomes, and also provide a basis for community planning. VDH district directors facilitate use of the data from these profiles and other resources in the community planning process. The State Team supports the community assessment process by providing data on outcomes, provides training and technical assistance, and whenever possible, provides financial support to help achieve agreed upon outcomes for children and families

The Vermont Primary Care Cooperative Agreement

One of the main purposes of the Vermont Primary Care Cooperative Agreement is to coordinate state primary care activities that promote the development of innovative and progressive primary care health care services for the underserved. The Vermont Cooperative Agreement provides opportunities for community-based providers of primary and specialty care to work together on state and regional issues and promotes the support and involvement of state agencies in primary care. The Vermont Cooperative Agreement includes representation from the following organizations, agencies, and institutions: Vermont's Agency of Human Services (Department of Health and the Office of Minority Health, the Department of Developmental and Mental Health Services, Department of Social Welfare – Medicaid); the University of Vermont (College of Medicine, School of Nursing, Department of Dental Hygiene); Imani Health Care (serving the African American, Latino, Asian, and Native American populations); Bi-State Primary Care Association; Dental Society; Health Care Authority; Coalition of Clinics for the Uninsured; Vermont Association of Hospitals and Health Systems; Medical Society; Nurses Association; Northern Counties Health Care; the Vermont Longterm Care Coalition; and the U.S. Public

Health Service Region I.

Coordination of Health Components of Community-Based Systems

The Division of Community Public Health has strong liaisons with Head Start, Early Head Start, and other early childhood programs. Staff from the Immunization Program in the Division of Health Surveillance and staff from the Division of Community Public Health work collaboratively with the AHS Division of Child Care to increase the percent of children in child care who are fully immunized. Vermont Department of Health staff participate in the statewide Early Childhood Workgroup, which was established to coordinate efforts between a variety of state agencies and private, not-for-profit community organizations. Two CISS grants from the Maternal and Child Health Bureau have increased the capacity of the VDH to focus on child and adolescent health systems development. The first grant was used to update the Vermont EPSDT periodicity schedule, which is being used as a vehicle to promote new approaches to child and adolescent health supervision, in particular, emphasizing health promotion and the prevention of psychosocial morbidity. Specific goals include streamlining or eliminating duplication in the delivery of child and adolescent health screening services and assisting VDH district offices in developing strategies to create, sustain or strengthen local systems of care and capacity to serve children, adolescents and families referred as a result of screening. The second CISS grant, Vermont Health Systems Development in Child Care increased the capacity of VDH to make health and child care a focal point in systems development efforts at the state level and created an interdisciplinary, community-based model for providing technical assistance to child care providers concerning health and safety issues. Staff from both projects work with the Early Childhood Work Group, Head Start, other state-level departments and agencies (e.g., the Department of Social and Rehabilitative Services, the Division of Child Care, the Department of Developmental and Mental Health Services, the Department of Education), and with private sector partners (e.g., the Vermont Chapters of the American Academy of Pediatrics and the American Academy of Family Practice).

The Vermont Department of Health works closely with the tertiary care facilities that provide services to Vermonters (Fletcher Allen Health Care in VT, Dartmouth Hitchcock Medical

Center in NH, and the Albany Medical Center in NY). Services are provided through the Newborn Intensive Care Units (NICU), the maternity service departments, health service providers through the Healthy Babies system of care and the CSHN programs. The VDH also has student nursing placements from the University of Vermont (Baccalaureate and Masters level), Norwich University, and Castleton State College nursing programs. VDH student placements are also provided for the Master of Social Work program and the Nutrition program at UVM.

VDH coordinated with the Department of Developmental and Mental Health Services in the development of the periodicity schedule, in order to better address the mental health needs of families through the primary care system. The Director of the Division of Community Public Health serves on the state team for the children's mental health grant, the Children's UPstream Services (CUPS) project.

The VDH is represented on Vermont's Interpreter Task Force. This is an interagency collaboration which develops and conducts non-English language interpreter and translator training activities. The task force monitors the need for interpreter services by Vermonters who don't speak English as their first language. VDH representation is via the Office of Minority Health and the Refugee Health Coordinator.

The VDH is represented on the state advisory team on welfare reform and continues to work with the Department of Social Welfare (DSW) in other ways as well. Improvements continue to be made to the WIC/Medicaid combined application and eligibility determination process, for example, and VDH and DSW collaborate to improve services and outcomes for parenting teens and their children.

The Vermont Department of Health has collaborated extensively with the Medicaid program in the implementation of the 1115 waiver, in meeting with managed care providers, and in planning for the CHIP benefits expansion. The state received a Robert Wood Johnson grant to improve outreach and enrollment of children in Medicaid and CHIP (Covering Kids).

VDH continues to coordinate efforts with the Department of Social and Rehabilitative Services (SRS) in the Fostering Healthy Families initiative, a program that addresses the needs of children in state custody. Particular attention is given to providing human sexuality education for children in state custody. In Bennington, a combined VDH/SRS project with foster parents has

been implemented to address alcohol and drug issues.

The VDH works with the Department of Education through the "Success by Six" and "Success beyond Six" programs. Another important collaborative relationship exists through the EPSDT School Access program. Each VDH regional office has a public health nurse/school liaison assigned to the task of improving access to health care for school aged children and strengthening the connection between VDH and the schools within their health district.

The VDH works with the Department of Corrections through local community partnership, Domestic Violence Task Forces, and child protection teams. For families who have a family member assigned to probation and parole, services are provided through local case management and Community Partnership meetings.

The VDH works closely with the Vermont Area Health Education Center (AHEC). Examples of collaborative activities are as follows: Office of Minority Health provides trainings to AHEC staff on cultural competency, VDH coordinates with AHEC in a variety of community activities, and the two organizations collaborate in developing training for primary care providers.

State Agency Coordination for CSHN

CSHN participates in a variety of interdepartmental MCH planning and policy making settings to assure that the needs of Vermont CSHN and their families are addressed. A special focus is the collaboration with the Children's section of the Division of Developmental Services, Department of Developmental and Mental Health Services, and with Medicaid. Please refer to the following discussions above: 1.5.1.2 Program Capacity, Systems of Care for CSHN, PYRAMID LEVEL: INFRASTRUCTURE, for description of CSHN collaboration activities."

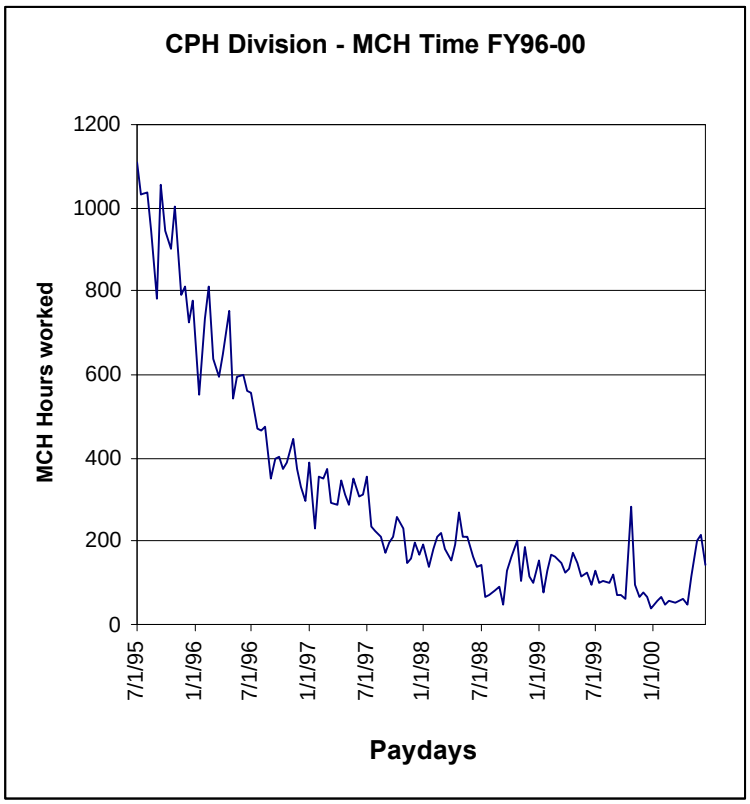
II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

FY99 Budgeted-Expended variation. Vermont's total State and Federal expenditures were about 3% higher than originally budgeted due primarily to higher staff salaries and ot her costs after the Budgeted estimate was made. Expenditures of Other Federal Funds was 2% higher than budgeted, primarily because a WIC expenditures increase more than offset low expenditures for Abstinence which did not have a full year of program activity.

Expenditure Changes. Total State and Federal MCH Block Grant expenditures increased from FY98 to FY99 by about $185,000 due to increased staff costs and purchased treatment costs. Expenditures for pregnant women declined by a small amount as staff time and funding were charged to Medicaid Administration rather than Title V. Total expenditures of Other Federal Funds increased from FY98 to FY99 about 6%. This increase was due primarily to increases in Medicaid (especially EPSDT in Schools), full implementation of the Abstinence program, and a higher level of spending for SSDI.

FY01 Budgeted. Budgeted amounts for FY01 continue to show a decline in expenditures for Component "A", especially for Pregnant Women due to the continuing shift of costs to Medicaid because of the Healthy Babies program. This has been a long term trend as the Medicaid claims have displaced MCH. The chart at the right illustrates the effect that Healthy Babies, and the associated Medicaid claims, have had on the time charged to MCH by Community Public Health staff over



the last several years.

In addition to the Medicaid charges in Community Public Health, Medicaid receipts have an effect on the charges to Components "B" and "C" through the cost-based clinic billings to Medicaid in the CSHN unit. The Department conducted an audit of its charges in FY00 and determined that, based on costs, an increase in the fees was warranted. This increase was substantial and will have the effect of reducing net charges to MCH in the relevant categories in FY01 and future years.

Expenditures by Service Categories. Actual expenditures by Types of Service (Form 5) from FY98-99 show a slight increase in each category except for Infrastructure Building. Looking forward to FY01, the projections indicate a marked decline in Direct Health Care and a small increase in all other categories. This sharp reduction in the relative share of Direct Health Care will have an effect on the profile of Vermont's expenditures in relation to the pyramid design. It does not, however, indicate a trend. It is the result of the increase in Medicaid reimbursements described above.

Accounting Procedures. All allocations of funds to the MCH Block Grant are determined in accordance with the Cost Allocation Plan approved by the DHHS Division of Cost Allocation. The Cost Allocation Plan, however, has no provisions for distributing costs within the Block Grant. As noted in last year's application we began allocating CSHN general support costs among all of the CSHN programs in FY98. In prior years, CSHN general support costs had been arbitrarily charged entirely to Component C. While this allocation uses exactly the same process as the allocations in the Plan approved by DHHS, this particular use of the allocation process has not been reviewed by the Division of Cost Allocation.

2.2 Annual Number of Individuals Served

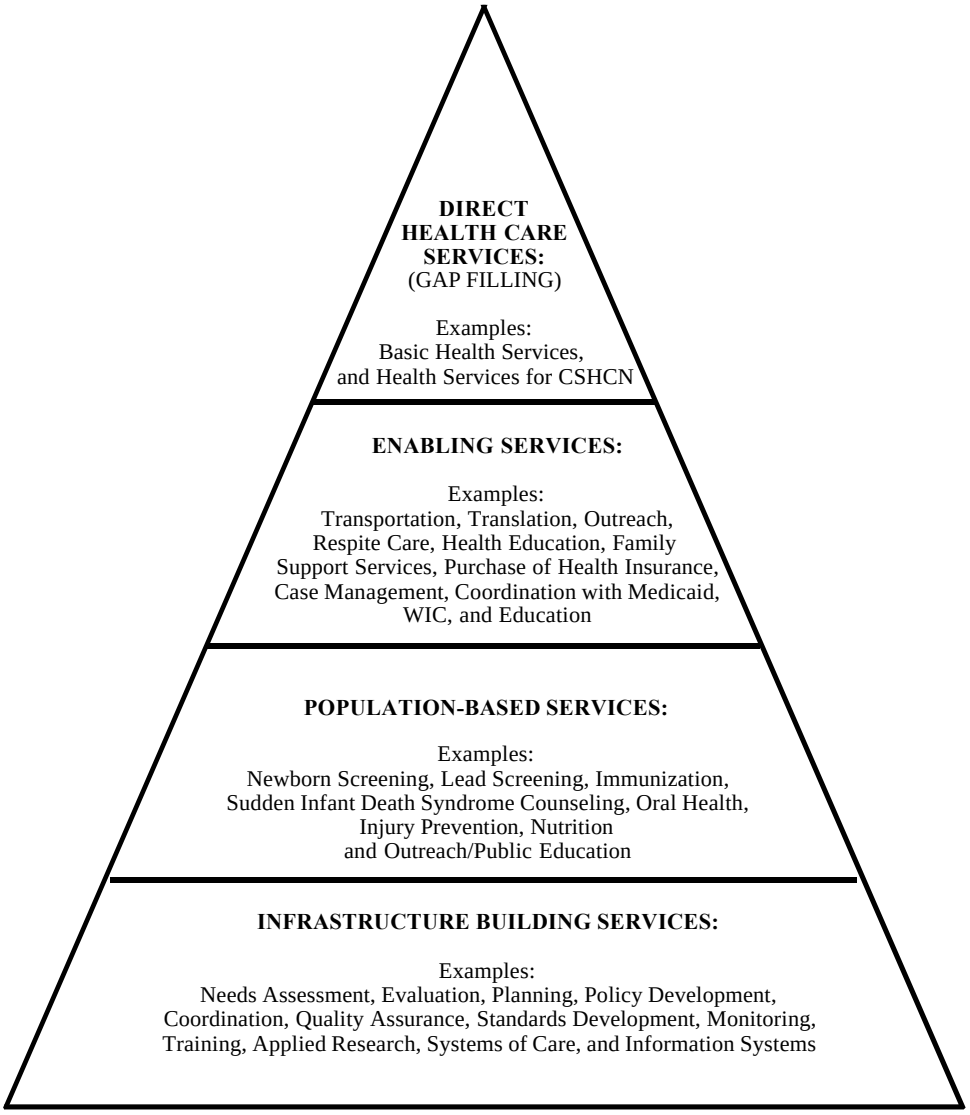
See ERP Forms 6, 7, 8 and 9.

2.3 State Summary Profile

See ERP Form 10.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/OSCH 10/20/97

2.4 Progress on Annual Performance Measures

The following section describes the accomplishments of the Vermont Title V program by each level of the pyramid by the relevant population groups. For individual program descriptions, please see Program Capacity, section 1.5.1.2.

Direct Health Care Services

Pregnant Women, Mothers and Infants

Healthy Babies, Vermont's prenatal and postnatal program, provides periodic home visits or group encounters to pregnant or postpartum women referred to the program. For prenatal clients, a comprehensive, trimester-specific curriculum is used. The content of the curriculum includes interim history, health care, psychosocial issues, maternal changes, fetal development, nutrition, breast feeding promotion and support, medications, substance use, activities of daily living, exercise, preparation for childbirth, preparation for parenthood, physical assessment, and recommended teaching aids. Home visits, group encounters, and telephone contacts are continued through the postpartum period. Postnatal services include assessment and teaching regarding physical status, parenting, health care, breast feeding, exercise, contraception, psychosocial issues, and referral to local services. In 1998, the Healthy Babies program began using the Maternal Postpartum and/or Newborn Follow-up Algorithm (see 5.3 Other Supporting Documents), which establishes specific criteria for the most appropriate follow-up care for mothers and babies after their hospital stay. The algorithm indicates a phone contact within 24 hours of discharge for all women and newborns and a scheduled visit as deemed appropriate by time of discharge, risk factors, and client's consent.

The Comprehensive Obstetrical Services Program, administered by the University Associates in Obstetrics and Gynecology in Burlington, provides comprehensive maternity care to women in northwestern Vermont, including clinical care and risk assessment, WIC nutrition services, nursing assessment and health education, and postpartum and family planning services.

The Family Planning Program provides reproductive health services including medical services (e.g., physical exams, screening for cancer and STDs, contraception, pregnancy testing) and health education programs. Services are offered at 12 Planned Parenthood of Northern New England sites statewide. The Vermont Medicaid program provides payment for family planning

services from PPNNE and private providers.

Children/Adolescents

The Family Planning Program also offers medical services to adolescents.

As a result of needs identified in the RWJ Making the Grade community assessment process, three communities have established school based health centers. These communities are the South Royalton School, the Newton School in South Strafford, and the Burr and Burton Academy in Manchester. These health centers have had a combination of 3300 patient visits since the first health center opened its doors in January, 1996. Acute care, physicals, mental health and substance abuse counseling, dental screening and referrals are some examples of the services offered at the clinics. The Making the Grade Project Director and Coordinator work in the Planning Division for the Agency of Human Services. The Robert Wood Johnson Foundation has funded the Making the Grade Program since 1996 and has recently agreed to extend funding for a fifth year so that other interested communities may explore the start up of school based health centers.

Children with Special Health Care Needs

Because this section reporting FY 1999 efforts towards accomplishing Direct Services outcomes for CSHN is largely duplicative of the Program Capacity discussion, please refer to 1.5.1.2, Program Capacity, Systems of Care for CSHN, PYRAMID LEVEL: ENABLING SERVICES, for more detail. FFY 1999 Updates follow below.

The Vermont CSHN program continues to provide family-centered, community-based coordinated services for Vermont children with special health needs and their families through direct services (clinics), care coordination, financial assistance, family support, and system-building activities.

<u>Enabling Services</u>

Pregnant Women, Mothers and Infants

The VDH ensures financial access to health services by promoting enrollment in the Medicaid program. Every family who comes into contact with the Department of Health staff is

screened to determine if they have adequate health insurance coverage, including preventive services. Those without adequate coverage are encouraged to apply for Medicaid benefits. A common, one-page application for Health Department services (including WIC) and Medicaid can be filed at any health or welfare office, allowing for simpler access to services.

The Healthy Babies system of care provides Direct Health Care Services, but also clearly fits under the Enabling Services section. Case management, counseling and health education, risk reduction intervention, home-based care, group education and other supportive services are bundled together in a Healthy Babies package tailored to meet the health needs of each individual woman. Effective December of 1996, Healthy Babies began reimbursement for perinatal group education for pregnant and postpartum women on Medicaid, thus increasing the accessibility of this education.

During FY99, the Healthy Babies administrative staff continued to focus on developing standards of MCH nursing practices. Focus on the perinatal continuum of care has resulted in more coordinated efforts to provide quality services to women and infants. This has resulted in enhanced referral systems for follow up both prenatally and at postpartum discharge from the hospital. A local partnership has published a "Path to Parenthood" packet of materials for each pregnant woman, which can be adapted for statewide use.

The Healthy Babies program has implemented MCH competencies statewide and offers regular trainings to home visitors to ensure consistency of care and to keep staff current in their knowledge and skills. An integral program component is case management, which includes referral to appropriate community resources and advocacy to obtain services for which eligibility has been determined.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is operating a nutrition and education program benefiting infants, children under age five, and pregnant, postpartum and breastfeeding women with low to moderate income levels. Nutrition education is offered at least twice during the client's certification period. Individuals with specific nutrition-related concerns receive additional nutrition education contacts from nutritionists. In Vermont, WIC has a long history of being thoroughly integrated with local public health services. For example, WIC provides referrals to the UVM smoking cessation project for peer counseling support, collaborates with the EPSDT Outreach and Advocacy Program, collaborates with the

Childhood Lead Poisoning Prevention Program, organizes and distributes food coupons to WIC recipients through the Farm to Family Program, and collaborated closely with the Healthy Babies System of Care.

The Smokers' Assistance Program provides supportive services to pregnant women who want to quit smoking. As of September 1998, 624 women had been referred for telephone peer support by WIC; 24% of these women reported during their last telephone support contact that they were abstinent from smoking. Based on data collected by WIC certifiers at the WIC clinic postpartum visit, 20% of the women in the program reported not smoking during the last three months of their pregnancies and 15% reported that they were currently abstinent. As of September 1998, 90 pregnant women smokers had been referred for telephone peer support by private providers; 30% of these women reported at their last contact with the support person that they had quit. During FY98, the program received an average of three new referrals per week from WIC and private practices combined.

The Nicotine Patch Project tests the impact of providing free nicotine patches with and without proactive telephone peer support to Medicaid-eligible women of childbearing age who wish to stop smoking. 425 women were eligible for the study and randomized into experimental (n=107) or comparison (n=107). The experimental groups received nicotine patch plus telephone peer support and the control group received only nocotine patch. Ninety-one percent of the participants were reached for the 3-month follow up assessment. At three months, 41% of women in the experimental group were abstinent, compared to 28% on women in the comparison group. This difference was significant ($p < .05$). For women in the experimental group, those who received more support calls and who used the nicotine patches for a longer time were more likely to be abstinent at three months.

The Refugee Health Program is instrumental in facilitating health evaluations for refugee families within 60 days of their arrival in Vermont. In FY99, close to 400 refugees were resettled in Vermont. Trends in resettlement show the majority majority of those resettling to be young families in childbearing years. Follow up shows that 90% of those arriving in the state have undergone initial health screening and appraisal.

Children/Adolescents

(See Refugee Health Program, above, under "Pregnant Women, Mothers and Infants.")

Since 1993, the School EPSDT Health Access program has facilitated a strong communication link between schools and the Vermont Department of Health. Although reimbursement is specific to school-aged children who are eligible for Medicaid, the program staff work closely with school administrators, school nurses and guidance counselors to identify children who lack access to health care services. This program is critical in our work to identify older children who have fallen between the gaps in health care access. In FY99, a number of VDH divisions, the Agency of Human Services Planning Division, the Vermont Department of Education, the University of Vermont, and others began collaborating to develop best practice guidelines to add to those distributed in FY98.

The Vermont Department of Health 1-5 Program, which began in July, 1998, provides oversight for home visits to children aged 1-5 years who are at risk for unnecessary and avoidable medical interventions. In fiscal year 1999, the program has served 263 children; 2,625 visits have been billed and paid during that time.

Fiscal year 1998 was the first year of the Children's Upstream Service (CUPS) grant in Vermont, which is designed to support and preserve families of young children who are at risk or are experiencing severe emotional disturbance (SED) through ensuring access to behavioral health and other community-based services. Grant activities include service implementation in accordance with the twelve regional CUPS plans, training and technical assistance, activities to strengthen family involvement, and program evaluation. This grant is expected to strengthen local interagency coordination and case review across the systems of care for children (early childhood and school-aged) and expand needed services statewide.

Concerns about poor access to dental care by Medicaid children stimulated a number of statewide efforts to gain information about the specific nature of the problem and develop strategies to improve the accessibility of dental services around the state. This process resulted in a funding request from the Vermont Governor's Office to the legislature to increase Medicaid reimbursement rates and provide grants to Vermont dental providers. As of July 1, 1999, Medicaid reimbursement rates to dental providers increased by 17%. In addition, the legislature allocated $400,000 for grants to dentists, hospitals, rural health clinics and schools to increase

dental services utilization by low income and Medicaid eligible Vermonters. These programs should serve as an incentive for dental practices to accept more Medicaid patients and for practitioners to view Vermont as a viable state in which to develop dental practices.

The Kids in Safety Seats (KISS) Program reflects a partnership between the VDH and the Governor's Highway Safety Program. KISS, through the 12 VDH district offices, trains families in the proper installation and use of child safety seats and offers subsidized car seats to low-income families for a nominal co-payment of $10 per seat. Program participants receive vouchers for approved car seats that can be redeemed at participating grocery stores. During the past five years, approximately 4,667 child safety seats for Vermont families have been subsidized by the KISS program. In 1999, trainings on appropriate installation and use of child safety seats took place statewide. In addition, fifteen car seat inspections were held, many in conjunction with KISS sponsored community-wide child safety seat awareness and training events. Approximately 1,000 subsidized seats will be distributed during 2001. During 1999, sixteen VDH employees became nationally certified to provide car seat training on proper car seat use to families and communities. This training was conducted by the American Automobile Association and the National Highway Safety Administration. To assure high quality services, only certified staff will be involved with KISS program activities.

All Vermont Kids Against Tobacco (VKAT) sites and 10 other Vermont schools and youth groups sent representatives to the Statehouse Rally and Youth Summit on February 10, 1999. Over 200 young people met with the Commissioner of Health and the Governor to discuss tobacco issues. Eight students from six VKAT sites presented information to the larger group and to the full House Health and Welfare Committee from the floor of the House. Other student activities around the state included anti-smoking presentations to youth, Operation Storefront, which is designed to raise awareness of tobacco advertising in Vermont towns, and participation in the Great American Screamout. In addition, activities were planned for World No Tobacco Day, Kick Butts Day, Tobacco Free Dances, and expanding drug free zones around school property.

CSHCN

Because this section reporting FFY 1999 efforts towards accomplishing Enabling Services outcomes for CSHN is largely duplicative of the Program Capacity discussion, please refer to 1.5.1.2, Program Capacity, Systems of Care for CSHN, PYRAMID LEVEL: ENABLING SERVICES for a full discussion. FFY 1999 Updates follow below.

The Vermont CSHN program, through its Special Services Program, continues to offer care coordination and access to specialized services for Vermont children who have a condition which CSHN covers but for which no established clinic exists. CSHN is also providing after-insurance funding of medical services when these services have been preauthorized by CSHN staff. Since 1993, CSHN has utilized an income-based Cost Share plan in conjunction with its financial assistance program. This program and its relationship to CHIP and Medicaid expansion are described above.

CSHN manages a Respite Care Program; eligible families receive assistance in hiring respite care providers when respite care from the Department of Developmental and Mental Health Services is unavailable. Demand for respite care for families has increased steadily each year.

CSHN is supporting Parent to Parent of Vermont to provide outreach to parents and community providers, training to medical and early intervention staff and students, and continuing education for CSHN staff and community providers. Part of the funding specifically supports the work of a parent as Children's SSI Coordinator, who is providing outreach information and referral to families whose children are receiving SSI but are not yet enrolled in CSHN; this effort expanded in FY99.

In-home support for children with severe disabilities is also being provided through the Medicaid-sponsored Personal Care Services (PCS); CSHN is one of the access points for PCS.

Population-Based Services

Pregnant Women, Mothers and Infants

Genetics services are being provided through the Vermont Regional Genetics Center. Clinic services are provided to individuals and families with known or suspected genetic conditions as well as to those who are at risk of genetic conditions. Services also include genetic

counseling, evaluation, diagnosis, and treatment of genetic conditions. In addition, the Vermont Regional Genetics Center is operating the pregnancy risk information toll-free hotline.

The Vermont Newborn Screening Program is providing screening services to all infants born in Vermont for phenylketonuria, galactosemia, homocystinuria, maple syrup urine disease, hypothyroidism, hemoglobinopathies, and biotinidase deficiency. In 1999, 99.4% of the infants born in Vermont were screened by this program.

The SIDS Program has been providing home visits to the families of SIDS victims and collects vital information about SIDS deaths. Grief counseling and education are provided in community settings such as child care centers when SIDS deaths occur. In addition, 2-3 Police Academy trainings occur each year, reaching up to 100 police officers annually. Since its inception in 1994, the "Back to Sleep" campaign has distributed materials to Vermont hospitals, Healthy Babies and other VDH home visitors and health care providers; over 4,000 informational packets are sent out annually to parents and caregivers who call the Parents Assistance Line.

During 1998, focus group research was conducted with low income families in Vermont to determine their barriers to fruit and vegetable consumption. The goal of the research was to foster the development of well-informed and effective strategies for increasing fruit and vegetable consumption among low income families. The results continue to be used by Vermont organizations to develop targeted nutrition education programs.

The Baby Bottle Tooth Decay (BBTD) Initiative coordinates prevention efforts among primary health care providers, dentists, dental hygienists and VDH staff (Dental Health Services, WIC and EPSDT outreach staff). Of the 260 general and pediatric dentists in Vermont, 136 have signed up to see all physician-referred children ages 0-4 who are at risk for developing BBTD, regardless of method of payment. The physician offices received a follow-up call in the winter of 1998 to reinforce the Initiative. In March 1999, the Dental Health Office at VDH mailed out 1,350 BBTD patient education packets to primary care physicians and all Vermont dentists. Through July, 1999, two update letters were mailed to all dental physician offices.

Enabling legislation was passed in 1998 to allow the establishment of a statewide immunization registry. The Immunization Program, in collaboration with the VDH Information Technology staff, is currently developing the specifications and implementation plan for the registry. The registry is expected to result in higher immunization levels and allow for easier and

faster assessment of the current immunization status of Vermont children. The implementation plans are expected to be developed by December 31, 2000.

Children/Adolescents

See paragraph above on enabling legislation for an immunization registry, as the project applies to this population group as well. In addition, the Adolescent Immunization Initiative continues to facilitate community planning and to provide technical assistance through the VDH district offices. Where a need is determined, public health nurses administer vaccines in school clinics. Beginning in the 1999-2000 school year, Immunization Regulations (effective July 6, 1998) will require pupils entering the 7th grade to have had or be in the process of obtaining three doses of hepatitis B vaccine. Under the same Regulations, effective July 6, 1998, every pupil in grades K-12 must have received a minimum of two doses of measles containing vaccine.

The Childhood Lead Poisoning Prevention Program (CLPPP) provides free blood lead testing for all children under age 6 throughout the state. Screening guidelines issued by the Department of Health in 1994 recommend universal screening of all 1-year-old children. These guidelines were revised in 1999 to include screening of all 1 and 2 year old children. In 1999, 63% of the 1-year-old population was screened for lead. Of the 6174 children under age 6 screened for lead in 1999, 94% had blood lead levels less than 10 micrograms per deciliter (µg/dl). When a child is diagnosed with severe lead poisoning (confirmed blood lead level $\geq$ 20 µg/dl) or has a persistent blood lead level between 15-19 a CLPPP risk assessor performs an investigation of the child's environment. In 1998, 20 investigations were performed. CLPPP staff also offers educational services to families of children with moderate lead poisoning (confirmed blood lead level of 15 – 19 µg/dl). In 1999, there were 31 families with children in this range. CLPPP staff have created pamphlets about the hazards of lead which have been translated into Vietnamese and Bosnian.

Vermont law requires that owners of rental property and child care facilities built before 1978 perform certain maintenance practices designed to reduce the risk of lead exposure to building occupants. These practices include receiving training in safe methods of working with lead paint. As of early 2000, 7,846 rental property owners, childcare providers and contractors have attended a training course.

Nutrition programs and activities included the revision of a manual for educators which links nutrition education guidelines, lesson plans and activities to Vermont Educational Standards. The manual was distributed by request through educator workshops and trainings. Also during the past school year, four schools participated in school-wide nutrition education projects. Each school developed a team which implemented a nutrition needs assessment, developed a school action plan, and received training and curricula linking classroom nutrition education to school meal programs.

In addition, a VDH nutritionist continues to participate in supporting the School Development Institute on Health Education. Previously, over 50 teachers have attended the UVM graduate credit course on developing health education curriculum and standard based health units. In addition, VDH continues its support of the Vermont Comprehensive School Health Institute, a three-day training for school teams.

The VDH school-based fluoride mouthrinse program currently serves 166 schools. A promotional effort directed to school principals in the spring of 1997 resulted in the addition of 14 new schools participating in the 1998/99 school year. The Dental Health Unit at VDH provides the school programs with supplies, training, materials and educational resources. For the past 21 years, Vermont has used a concentrated sodium fluoride powder which had to be mixed and dispensed by school personnel. In FY99, a unit-dose system (begun in 1998) was further modified by sending the fluoride mouthrinse directly to the schools.

Through the coordination of oral health prevention efforts among primary health care providers, dentists, dental hygienists, and Department of Health staff, Vermont physicians have been encouraged to determine the fluoride level of each patient's primary water supply and to prescribe fluoride supplements as needed. Vermont family and pediatric physicians have been provided with a booklet containing the fluoride levels of all public water supplies and the necessary forms to order a free water test for patients with wells. To date, at least 86 dental and medical providers have used the fluoride test form at least once.

The Office of Alcohol and Drug Abuse Programs at the Vermont Department of Health was awarded a State Incentive Cooperative Agreement (SICA) Program grant to develop a coordinated funding system for substance abuse prevention efforts. The system funds communities to develop and use research-based comprehensive prevention strategies for reducing

alcohol, tobacco, marijuana and other drug use among Vermont youth. SICA is in its third year of implementation; community sub-grantees are in their second year of implementation. In 1998, 23 Vermont community coalitions were funded to implement substance abuse prevention plans at a total of $2.3 million. These coalitions represent an array of towns, school districts and regional partnerships; interventions are targeted to youth, adults, and the systems that influence them. Funded strategies include Life Skills Training curricula, parent support and skill building opportunities, mentorship programs, coalition development and community mobilization aimed at changing norms and policies that encourage substance use.

CSHCN

Because this section reporting FFY 1999 efforts towards accomplishing Population Based Services outcomes for CSHN is largely duplicative of the Program Capacity discussion, please refer to 1.5.1.2, Program Capacity, Systems of Care for CSHN, PYRAMID LEVEL: POPULATION BASED SERVICES for more detail. FFY 1999 Updates follow, below.

The Vermont CSHN program is providing follow up on all newborns who have had positive screens through the Vermont Newborn Screening Program for metabolic, thyroid, and hemoglobin disorders. CSHN provides clinic based care and care coordination services for such children, as well as metabolic foods when part of the treatment plan.

CSHN is participating in the statewide expansion of the Hearing Outreach Program (HOP), in partnership with a consortium of Vermont hospitals. The program makes available outpatient otoacoustic emissions hearing screening, performed by a pediatric audiologist, for infants and young children or hard-to-test older children. HOP has expanded to providing screening at 12 sites across the state. HOP is also moving from a targeted program to one of universal screening.

Vermont CSHN and MCH are collaborating closely with the March of Dimes and its three year campaign to increase the intake of folic acid among females of childbearing age. Vermont has provided the state match necessary for a short, intense March of Dimes grant to support an aggressive public education about the importance of adequate folic acid intake. CSHN input has helped to select from some of the prepared materials those which might be most effective, and

those which carried a message which would not be as well received in Vermont. CSHN and other VDH staff participate in an advisory council to the March of Dimes outreach education person.

Infrastructure Building Services

Pregnant Women, Mothers and Infants

The Vermont Regional Perinatal Program (VRPP) of the University of Vermont provides perinatal outreach services to six Vermont community hospitals. These services include transport conferences, review of community based perinatal statistics and multidisciplinary professional education updates for health providers who care for pregnant women and newborns. In FY 99, a total of 27 conferences were held at community hospitals. Two regional workshops, entitled: "Complications of Pregnancy: Implications for Care", and "Perinatal Management and Outcomes: Critical Issues and Challenges" were held in conjunction with the New Hampshire Perinatal Program in the spring of 1999. In addition to traditional educational services, VRRP organizes quarterly meetings with the Vermont hospitals' Perinatal Nurse Managers. These meetings provide a forum for identification of current issues, educational opportunities, and networking.

An "Assessment of Family Planning Service Needs" was conducted and distributed in the winter of 1998. While it identified many successes in Vermont, it also identified gaps such as a high proportion of unintended pregnancy, failure to reduce the birth rate among older adolescents (ages 18-20), and difficulty in accessing family planning services. The Department of Health is working with Planned Parenthood of Northern New England (PPNE), the state Medicaid and VHAP programs, and others to address these issues.

The Office of Minority Health in the Vermont Department of Health has provided the first tier of training in cultural competency for Department of Health staff for the last three years. This infrastructure-building activity, which has been listed as a performance measure throughout this time period, is relevant for all three population groups served by Title V. In FY99, 100% of the MCH staff at VDH completed the first tier of training, which is now included in the orientation for all new health department employees. The second tier of cultural competency training is now being provided to staff (although not required) and consists of more in-depth subject material.

During FY99, the Healthy Babies system of care conducted statewide training sessions for

all Healthy Babies home visitors. Training topics included childhood injury and safe environments, well child periodicity schedule, updates on immunizations and lead poisoning, social and rehabilitative services, and engaging the difficult client.

The woman's health coordinator continues to work towards a comprehensive assessment of health needs and issues for Vermont women across the lifespan. In an important step towards this goal, seven focus groups with women of all ages have been conducted in various locations across the state. These focus groups examined Vermont women's view of health, important issues for women in their communities, barriers to health, and desired resources. The women's health coordinator also continues to serve as a link between the VDH and several statewide multi-agency task forces and ad hoc committees which are working to improve various aspects of women's health. In the past year, the Vermont Osteoporosis Task Force held two awareness and screening events, and developed and distributed a how-to guide for creating an osteoporosis awareness event to hospitals and health department district offices throughout the state. The Sexual Violence Prevention task Force has continued to work towards identifying statewide goals for the primary prevention of sexual violence. The newly convened HPV (Human Papilloma Virus) Working Group has begun work on a statewide survey of attitudes, behaviors, and needs of school nurses around the prevention of this sexually transmitted infection, with the ultimate goal of reducing cervical cancer. The woman's health coordinator is also partnering with Ladies First, Vermont's breast and cervical cancer screening program, to reach program participants with a wide range of women's health information through writing a women's health column for a newly created newsletter and developing modules for training outreach workers on a variety of women's health topics.

Children/Adolescents

The Bureau of Primary Health Care (BPHC) is providing funding for the Primary Care Cooperative Agreement to advocate for and coordinate state primary care activities that promote the development and provision of innovative and progressive primary care services for the underserved. The Vermont Cooperative Agreement aids in planning for primary care resources, provides opportunities for community-based providers of primary care to work together on state and regional issues, promotes the support and involvement of State agencies in primary care, and

provides for training and technical assistance.

The Community Water Fluoridation Program reports that Vermont currently has 29 public water systems, made up of community and district suppliers, that provide fluoridated water to 43 communities statewide. Based on a Vermont Department of Health Laboratory analysis, 86% of the fluoridated public water systems maintain optimal fluoride levels.

The MCH Planning Specialist has been serving on the Child Fatality Review Committee to link the efforts of the Committee to ongoing Vermont Department of Health efforts concerning infant mortality, childhood injury, and other causes of death to children and adolescents. The Division of Health Improvement is currently in the process of developing a data collection system and database designed to systematically assess factors that may be associated with deaths from such events as Sudden Infant Death Syndrome (SIDS), child and adolescent deaths from injury, and youth deaths from suicide. These activities are being coordinated with the efforts of the recently hired coordinator for the Injury Prevention Program.

In FY99, the new EPSDT periodicity schedule was completed and distributed to all primary care providers and school nurses in Vermont. In FY99, the Department developed a tool kit of materials supporting the EPSDT periodicity schedule developed in FY98. The Department worked closely with the Vermont chapters of the American Academy of Pediatrics and the American Academy of Family Practice to develop the materials, and presented the project at the joint meeting of the two groups.

The Community Integrated Service Systems (CISS) Health Systems Development in Child Care grant program, "Healthy Child Care Vermont," enabled the Vermont Department of Health to increase health representation in child care forums, focus attention on child care issues in health forums and in health systems development work at the state level, and begin to meet the health consultation needs of child care providers. Staff members have developed Core Standards for home-based early childhood programs and have worked with child care, mental health, and Success by Six representatives on strategies to support child care providers regarding emotional and behavioral issues of some of the children they serve. Healthy Child Care Vermont established pilot projects in three areas of the state, developing a comprehensive Teaching and Consultation Tool Kit. Each Tool Kit addresses 10 health and safety topics and includes a 2-3 hour workshop design with materials for child care providers, children and families, as well as supporting

materials for the Child Care Health and Safety Consultant who provides on-site consultation.

The second CISS grant, the Community Organization grant, is developing a Vermont-specific model for comprehensive child health supervision and promotion and will be active in the implementation and dissemination of that model in Vermont's changing health care system, with particular attention to ensuring adequate referral and follow-up systems at the community level. Working with public and private partners and using the EPSDT periodicity schedule as the cornerstone, the project is developing state-specific, primary care guidelines in the areas of medical and dental risk assessment, developmental/behavioral screening, mental health promotion, and preventive mental health interventions. The project is also working at the state and local levels to design approaches to systems problems in implementation, with emphasis on Medicaid managed care, and is working with VDH district offices and communities to develop local strategies to create, sustain or strengthen community systems of care for children and adolescents. Examples of local level projects include a work group focused on improving access to dental care by children who have Medicaid. The development of a "Nursing Grand Rounds" was designed to provide regular educational and networking opportunities for community-based nurses in private practices, schools, clinics, youth rehabilitation facilities, home health, and public health settings in Vermont's most populated county. This program has been expanded to all areas of the state.

During FY99, the Emergency Medical Services-Children (EMS-C) Partnership project continued to provide education and training in the planning and delivery of the annual Vermont EMS Conference, the delivery of the Basic Life Support Pediatric course and the University of Vermont's Pediatric Office Resuscitation Project. Assistance was provided in the development of state wide clinical protocols and the revision of the EMS rules. Technical assistance in the development of injury prevention programs was provided to EMS services.

CSHCN

Because this section reporting FFY 1999 efforts towards accomplishing Infrastructure outcomes for CSHN is largely duplicative of the Program Capacity discussion, please refer to 1.5.1.2, Program Capacity, Systems of Care for CSHN, PYRAMID LEVEL: INFRASTRUCTURE, for more detail about specific systems building activities. FFY 1999 updates follow below.

This section, as in 1.5.1.2 Capacity, is organized according to the six CSHCN systems outcomes articulated by MCHB/CSHCN and used as a basis for the MCHB funded Measuring and Monitoring Project (Utah State University). The full description is contained in 1.5.1.2. Specific updates are below.

Children receive regular ongoing care within the medical home.

In FFY 99, CSHN has continued to support and participate in two projects enhancing the ability of primary care to provide a medical home model practice, the MCHB-funded Rural Medical Home Improvement Project and the originally SSDI- and now Healthy Tomorrows Partnerships-funded "Whatever It Takes" project. In addition, CSHN has been a vocal participant in the development of the new Medicaid primary care case management model, "PC Plus", which began to be implemented in October, 1999.

Families have adequate insurance to pay for needed services.

With the expansion of Dr. Dynasaur (Medicaid and CHIP) to 300% FPL, Vermont continues to improve the percentage of children who have a source of adequate health care coverage.

In FFY 99 Medicaid continues to delegate to the CSHN director the responsibility for determination of the medical necessity and authorization of continuation of service for OT, PT and speech services for children after they have received them for a year. CSHN also continues to review and facilitate the ordering of wheelchairs and other seating and positioning equipment, as well as the coordination of insurance and Medicaid coverage for the equipment. In addition, the CSHN director continues as one of three interagency staff who review children's applications for Personal Care Attendant Services.

CSHN continues to make available access to pediatric specialty providers (particularly OT, PT and nutrition) who are not part of the Medicaid provider network (Medicaid does not enroll providers in individual practice in these disciplines). CSHN continues to advocate with Medicaid for an arrangement that will address this systems issue; we have recommended that CSHN itself be recognized as a provider agency of these services. A similar arrangement has been made for CSHN to be a vendor of metabolic food and formulas.

Children are screened early and continuously for special health care needs.

(This paragraph is repeated from 1.5.1.2, because most of the capacity as been developed in the 1999 reporting year.) CSHN is increasing efforts to encourage universal newborn hearing screening, with hospital nursery screening as the starting point in a system of assurance. During the reporting year (FFY 99) and presently, Vermont does not have a system for assuring that all newborns are screened for congenital hearing loss while in the hospital nurseries. However, in response to the guidance of CSHN's Advisory Council on hearing issues, CSHN partnered with the Vermont Association of Hospitals and Health Systems (VAHHS) and with Fletcher Allen Health Care (FAHC) to establish a statewide network of hearing screening clinics, the Hearing Outreach Project (HOP). In 1999, the legislature required VDH to establish a study commission to determine and report upon what it would take to implement universal newborn hearing screening in VT. The CSHN director chaired this commission. The Executive Summary of this report is contained in the appendix. The report recommended that hospital nurseries be urged to begin UNHS, that VDH could be a source of technical assistance, that HOP evolve from a network of clinics performing targeted hearing screening for young children to a statewide follow up and assurance system for UNHS. These goals could be implemented without any state mandate to do so, following the model of Vermont's newborn metabolic (bloodspot) screening program. At the time of this writing, HOP has collaborated with four community hospitals to the point of their selecting the screening equipment, and two (one in FFY 99) have begun screening all newborns. It seems very likely that other hospitals will participate in the near future. CSHN is positioned to continue to support the effort with technical assistance and follow-up from the Hearing Outreach Project.

Families are decision makers and satisfied with services.

CSHN relies upon and collaborates with Parent to Parent of Vermont and its network of supporting and participating families, for guidance and input about program quality and direction. Please see section 3.1, Needs Assessment, for a discussion of this aspect of infrastructure and systems-building.

Services are organized in ways that families can use them easily.

CSHN continues the above described efforts to strengthen community-based nutrition services capacity. In addition, CSHN supports the capacity of community-based OT and PT, by contracting with two pediatric therapy provider agencies, considered by their peers to be highly expert in the fields. The contracts support their attendance at CSHN clinics and their availability to community-based therapists for consultation

As nationally, Vermont is experiencing a shortage of home-based care providers, including nurses, nurses aides, and personal care attendants. CSHN is working very closely with other departments and programs within the Agency of Human Services, to find and implement strategies to increase the numbers of hours of Personal Care attendant Services which families are able to fill with attendants with who they are satisfied. By the end of FFY 2001, there should be a measurable indication of success of the strategy (the percentage of hours allocated which have been utilized).

CSHN's systems-building efforts are greatly strengthened by its participation in New England SERVE discussions and collaboration, and in the Association of Maternal and Child Health Programs (AMCHP) and its committees. The CSHN director serves on the AMCHP Policy and Programs committee. Recent New England SERVE facilitated discussions have included such essential topics as newborn screening, and the relationship between CSHCN programs and tertiary care centers.

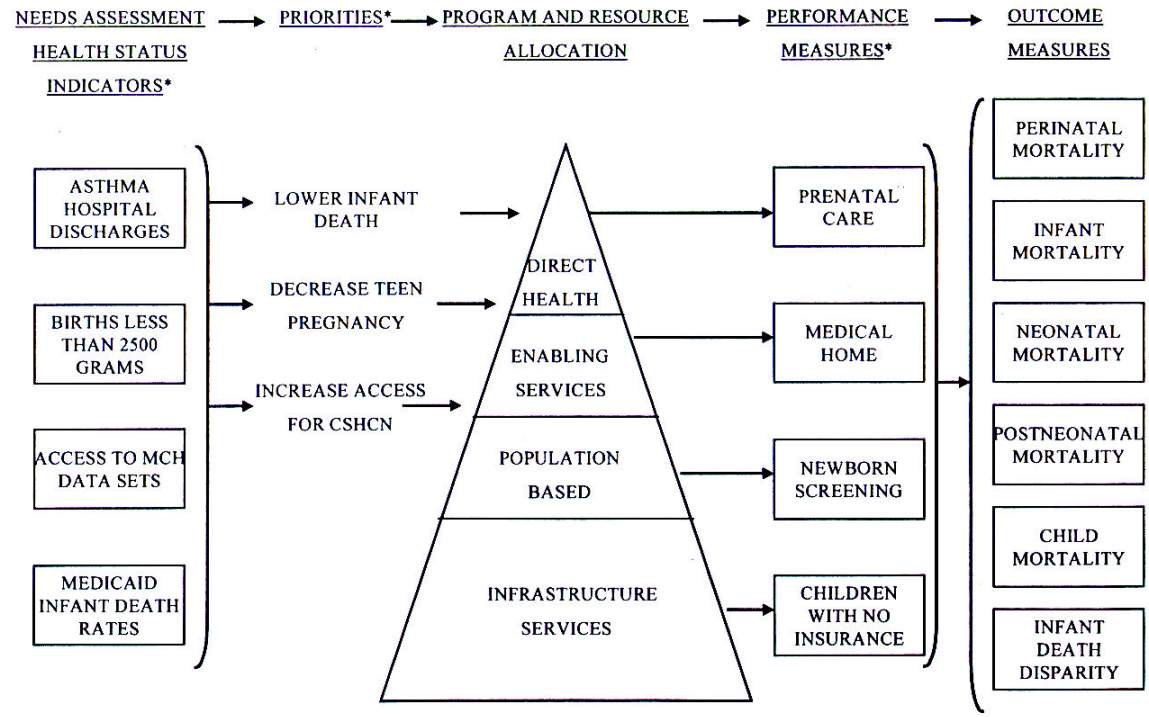
Youth receive services necessary to transition to adulthood

The Department of Social and Rehabilitative Services (SRS) has recognized that some children and youth in foster care have serious special health needs, and that the disruption in their home stability and placement may make them particularly vulnerable. The CSHN director continues to participate on a monthly interagency committee which provides consultation/case reviews to assist the local SRS team in supporting the child. As many of the children are adolescents, often the critical care issues include long term planning for the special health need, particularly as other sources of care, such as education, also have major points of transition at the same time.

CSHN has a written agreement with the Division of Vocational Rehabilitation concerning the mutual referral/acceptance of clients.

CSHN participates both on a case-by-case basis (which informs the system) and an interagency basis, to smooth the transition from pediatric in-home support services such as Personal Care attendant Services to other programs which may provide similar supports. These latter programs are Medicaid Home and Community Based Services Waivers within the Department of Developmental and Mental Health services and the Department of Aging and Disabilities.

Figure 3
TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



*Items in these columns are samples drawn from complete sets described elsewhere in this document.

National Performance Measures

1) *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program*.

In Vermont, children who are eligible for SSI are automatically eligible for Medicaid. Medicaid, because of its EPSDT requirements and because of the state's interpretation of Medicaid intentions, offers the broadest and deepest coverage of health care needs for children, including full implementation of services such as Personal Care Services (attendant care). Many children with SSI are also enrolled in CSHN programs or in other state agency programs such as Developmental Services. In the last year, we reported this situation as making the CPM#1 inapplicable to Vermont. This year, we can also report that 43.2% of children with SSI under age 16 were also enrolled in one or more CSHN programs. Enrollment in CSHN means that children and their families receive the attention of care coordination and support, even when payments for direct services were not required. The long term objectives for this measure are being developed within the present planning activities of CSHN.

2) *The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients*.

All of the specialty and subspecialty services listed in this performance measure are currently provided by the CSHN program, so the 100% baseline figure (9/9) is also the annual performance objective through FY2001. See ERP attachment for Performance Measure #2.

3) *The percent of Children with Special Health Care Needs (CSHCN) in the state who have a medical/health home*.

Other than the application of the estimate of 18% to the general population of children (18% of 141,966 = 25,553), we continue to lack a definitive count of CSHCN. We continue to use the approximation of the proportion of families referred to CSHN in CY 99 who reported that their child has a primary care physician. This proportion (1,040 of 1111 referred children, or 93.6%) is then applied to the 25,553 estimated CSHCN statewide (23,918). This percentage exceeds the

goal for the reporting year. This is a more accurate estimate than last year; we have information on a larger number of referred children, because of the development of a database for children in Child Development Clinic.

We believe that because of Vermont's very high percentage of insurance and/or Medicaid coverage for children, families have excellent access to primary care; therefore, it is not surprising that most report having a PCP. However, in our needs assessment (both in the written survey and in the focus group) (see 3.1 below) with parents of CSHN around the state, we asked parents to reflect on the AAP's comprehensive definition of a medical home. A typical reaction in each focus group was that, while nearly all parents had a PCP for their child, far fewer (only 16 of 93, or 17%) felt that they had experienced a medical home. We also believe that these focus groups were more broadly representative of Vermont CSHCN than those children who are referred to CSHN programs; the focus groups sought, and included, parents whose children had conditions not "covered" by CSHN, particularly those with mental health concerns Similarly, in the written surveys, only 194 of 335 parents responding (58%) said they had a medical home as defined.

4) *The percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies*.

Data are available for this measure from the Vermont Newborn Screening Program. We surpassed our target of 98.9% by screening 99.4% in 1999. Given that a small fraction of parents are likely to persist in refusing screening, this percentage may have little room for progress.

5) *The percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B*.

The July 1998-June 1999 National Immunization Survey data indicate that 88.9% of Vermont's 19-35 month old children have completed the 4:3:1:3 series of immunizations (four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more dose of measles containing vaccine, and three or more doses of Hib). We exceeded our target by 2% in FY98. Vermont was tied for second highest rate in the country for these immunizations. The Vermont rate for three or more doses of hepatitis B vaccine from the same survey was 90.8%. Vermont's high rate of immunizations is due to several factors: a long standing universal vaccine distribution system,

which provides free vaccines to all medical providers; the WIC program requires participants to provide immunization documentation at clinic visits; and children in licensed child care settings are required to be up to date on their immunizations, with child care providers responsible for reporting immunization status to VDH. Technical assistance and support are provided to families and child care operators in meeting these requirements by various VDH staff.

6) *The rate of birth (per 1,000) for teenagers aged 15 through 17 years*.

Data are available from the Division of Health Surveillance. In 1998, the teen birth rate dropped to 11.4 per 1,000 Vermont teens down from 12.1 in 1997. Our annual performance target for FY98 is 15/1,000. Reasons for this continuing improvement are unlikely to be due to any single intervention. Rather, we believe it is related to the overall societal changes that are reflected in reductions in teen pregnancy nationally and the accessibility of services statewide. The Vermont YRBS indicates fewer teens are having sex, and when they do, are more likely to be using birth control. Sex education is one of the required components of the Vermont health education curriculum, and confidential family planning services are available through Medicaid as well as Title X and state funded programs. We believe that our success in this area is related to our multi-faceted approach to teen pregnancy prevention described in the program activities. A strength of this approach is that it contains strategies delivered at both the state and community levels.

7) *The percent of third grade children who have received protective sealants on at least one permanent molar tooth*.

Data on all third grade children are not available for this performance measure, and we continue to need to rely on the 1997 estimates of 41% of all eight year old children on Medicaid receiving protective sealants on at least one permanent molar tooth. This percent is lower than the 1996 estimate of 43%, which was derived from a 93-94 statewide oral assessment survey of Medicaid and non-Medicaid 3rd graders. In addition, this indicator is below the performance objective for FY97. Because we have not been able to include children with private dental insurance, this indicator underestimates the true number of third graders who have received protective sealants. The Dental Health Unit is working with Medicaid to develop an ongoing, systematic data capacity

to access information of this type for future evaluation and planning.

8) *The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children*.

These data are available annually from the Division of Health Surveillance and indicate a rate of 3.7 deaths per 100,000 Vermont children ages 1-14. The number of child fatalities due to motor vehicle crashes remains relatively stable; despite a decrease in the number of children ages 1-14. We did not achieve our FY98 target of 4.2/100,000. One cautionary note regarding this rate, for future reference: because Vermont's population size is small and child fatalities from this cause are rare, the rate can fluctuate greatly from year to year. One "extra" accident that results in the deaths of several children might make the rate jump up dramatically for a given year.

9) *The percentage of mothers who breastfeed their infants at hospital discharge*.

Population wide data are not available for this performance measure. The closest proxy available is from Vermont's WIC Program data from CY 98, which indicates that 56% of infants born to mothers receiving WIC were ever breastfed. This is somewhat under the annual performance objectives for FY98. Many statewide and community activities continue to advance support of mothers who breastfeed, such as provider training, breastfeeding support groups, and MCH Coalitions which are working to improve the breastfeeding climate in hospitals, including increasing the number of nurses in maternity units who have advanced training in breastfeeding support.

10) *The percentage of newborns who have been screened for hearing impairment before hospital discharge*

In FFY 99, the two tertiary care hospitals caring for VT newborns in Newborn Intensive Care Units (FAHC in Burlington, VT, and DHMC in Lebanon, NH) continued to screen all NICU babies for hearing loss before discharge. However, the specific state of residence of each baby screened was not coded, so that the reports from the NICU's represent an estimate, that is, the percentage of VT births applied to the total number of NICU babies screened. In addition, however, in January, 1999, one community hospital began screening the hearing of all its

newborns. This number is added to the NICU screenings for this year's report, and account for the state exceeding its FFY 99 goal (which was 4.4%). At the time of this report, only Calendar Year births in 1998 are available (but believed to be very close to 1999 births); there were 6,569 births. In 1999, 631 newborns were screened at their birth hospitals, or 9.6%.

CSHN is increasing efforts to encourage universal newborn hearing screening, with hospital nursery screening as a starting point in a system of assurance. During the reporting year (FFY 99) and presently, Vermont does not have a system for assuring that all newborns are screened for congenital hearing loss while in hospital nurseries. However, in response to the guidance of CSHN's Advisory Council on hearing issues, CSHN partnered with the Vermont Association of Hospitals and Health Systems (VAHHS) and with Fletcher Allen Health Care (FAHC) to establish a statewide network of hearing screening clinics, the Hearing Outreach Project (HOP). In 1999, the legislature required VDH to establish a study commission to determine and report upon what it would take to implement universal newborn hearing screening in Vermont. The CSHN director chaired this commission. The Executive Summary of the report is contained in the appendix. The report recommended that hospital nurseries be urged to begin UNHS, that VDH could be a source of technical assistance, that HOP evolve from a netwrok clinics performing targeted hearing screening for young children to a statewide follow up and assurance system for UNHS. These goals could be implemented without any state mandate to do so, following the model of Vermont's newborn metabolic (bloodspot) screening program. At the time of this writing, HOP has collaborated with four community hospitals to the point of their selecting the screening equipment, and two (one in FFY 99) have begun screening all newborns. It seems very likely that other hospitals will participate in the near future. CSHN is positioned to continue to support the effort with technical assistance.

11) *The percent of Children with Special Health Care Needs (CSHCN) in the state CSHCN program with a source of insurance for primary and specialty care.*

The CSHN program obtains information about patient insurance staus at each visits for which an encounter form is filled out. The figure reported here is the percentage of CSHN-enrolled children for whom one or more health insurances (including Medicaid) were identified at

visits. In FY 1999, there were 3,469 "active" CSHN children whose encounters were recorded, and at 98.1% of those encounters, the child had one or more insurances (including Medicaid). The denominator, and hence, also the numerator, are an undercount of the true number of "active" CSHN children because not all enrolled children attend a CSHN clinic, and it is only at these clinics that encounter information is gathered. It is unknown whether the CSHN enrolled children who do not have encounter information have the same high percentage of insurance.

12) *The percent of children without health insurance*.

Data on this performance measure are also based on the 1997 BISHCA survey. This survey indicated that 4.2% of Vermont children ages 0–17 were without health insurance in 1997; this figure serves as the baseline for this measure. Data for FY98 are estimates based on the 1997 survey and 1997 population estimates. The next BISHCA survey is planned for 2000. We did not reach our annual performance target in FY98 possibly because the expansion of Medicaid to 300% FPL for Vermont children went into effect in October, 1998 rather than in July 1998, as expected. We anticipate receiving a Robert Wood Johnson grant which will fund a community-based, outreach program to enroll and maintain all Vermont children on Medicaid who are eligible but not currently enrolled.

13) *The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program*.

Data are not available on the number of children who are potentially eligible for Medicaid but who have no contact with the system. Therefore, the denominator includes only those children who are enrolled in Medicaid. In 1998, 90.5% of Medicaid enrolled children received a service paid for by the Medicaid program (not including pharmacy-only recipients).

14) *The degree to which the state assures family participation in program and policy activities in the state CSHCN program*.

Our score on the Six Characteristics Documenting Family Participation in CSHCN Programs

remained stable at 15 this year. Item #1 has decreased this year; although several advisory committees continue to meet and have significant parent representation, the main CSHN Advisory Council has not met during the needs assessment process and will reconvene this fall to review the findings and give us guidance. On the other hand, item #3 has increased because of the more focused needs assessment process.

15) *The percent of very low birth weight live births*.

Data are available on this measure from the Division of Health Surveillance and indicate that in FY 98, Vermont's percent of VLBW was 1.4, higher than the objective of 0.8. Many very low weight live births cannot be predicted in advance by risk screening, so our primary strategies for preventing very low weight births continues to be assisting women to enter prenatal care early in their pregnancies and to focus on smoking cessation.

16) *The rate (per 100,000) of suicide deaths among youth aged 15-19.*

Data are available on this measure from the Division of Health Surveillance and indicate a rate of 2.3 suicide deaths per 100,000 Vermont youth aged 15-19 in 1998. Although this appears to be a dramatic decrease from 1996 when the rate was 7.3 per 100,000, it is actually an artifact of small numbers. In 1996, there were three suicides among 15-19 year olds, whereas in 1998 there was only one.

17) *The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates*.

In 1998, 83% of the very low birth weight babies were born in a tertiary care hospital. This indicator is down slightly from the FY96 baseline figure of 85.1% and does not reach the objective of 87%. On-going efforts for this measure include activities of the Vermont Regional Perinatal Program and Healthy Babies system of care, increased attention to the issue of birth outcomes by the Commissioner of Health and the Vermont Program for Quality in Health Care, and regional meetings held by the Commissioner of Health regarding birth outcome data.

18) *The percent of infants born to pregnant women receiving prenatal care beginning in the first*

trimester.

Data are available on this measure from the Division of Health Surveillance and indicate that in 1998, 87.4% of Vermont infants were born to women receiving prenatal care beginning in the first trimester. This remains about the same as the 1997 percent of 87.9, and is equivalent to the objective of 87%. The Healthy Babies system of care continues to work closely with obstetrical care providers to assure that women enroll in care early in their pregnancies. Health Department assistance with Medicaid/VHAP enrollment and Medicaid coverage for pregnant women at 200% of poverty contribute to our success in this area.

State Performance Measures

1) *The percent of Medicaid infants from birth through 12 months who receive a home visit through the Healthy Babies system of care*.

In 1999, 43% of infants-12 month olds on Medicaid received home visits through the Healthy Babies system of care. We have essentially maintained the level of home visiting services from the previous year through continued coordination with the hospital discharge planning process and referrals for postpartum visits. into effect. In order to more fully engage more families, efforts to develop an expanded menu of service options for the infant's first year of life will be a priority over the next year.

2) *The percent of low income children (with Medicaid) who utilize dental services in a year*.

These data are available through the Medicaid program and indicate that 45% of children on Medicaid used dental services in 1999. Although we did not reach our target of 50%, we did increase dental services utilization for the number of children served by over 2,000 from 1997. One challenge in tracking progress over time on this measure is the fact that, as more children become eligible for services through the CHIP program, it may be more difficult to keep up with the provision of services. As the denominator grows larger, this percentage may decline, even if a greater number of children are being provided with dental services.

3) *The percentage of Vermont Department of Health districts that have a community-based hearing screening and diagnostic follow-up program (Hearing Outreach Program) for children*.

In FFY 99, the Hearing Outreach Project expanded to 13 sites, covering all 12 AHS districts and exceeding our goal, which had even been revised upward last year. See also Core Perfomance Measure #10.

4) *The percent of primary caretakers in the Women, Infants and Children (WIC) program who report placing infants to sleep on their backs as the usual sleeping position*.

These data are not currently available. Revision of screening forms used in WIC was delayed while Vermont implemented a new mandatory national system of risk criteria for the WIC program. Form changes to capture this information have been implemented. However, until a new client management information system is implemented, the data will need to be extracted from the records manually. Therefore, baseline data will probably be available before Fall 2000. At that time, the annual performance objective will be reevaluated, also.

5) *The percent of youth aged 12-17 who use alcohol*.

In FY99, the percent of youth (aged 12-17) who use alcohol was 44%, which was better than the target of 47% and down from the 51% for FY97. The Vermont Youth Risk Behavior Survey (YRBS) is conducted every other year (1995, 1997, 1999) and is providing a consistent opportunity to evaluate the progress in this measure. YRBS data are based on responses by 8th through 12th grade students and do not include those who have dropped out of school.

6*) The percent of 8th grade youth who smoke cigarettes*.

In FY99, the percent of eighth grade youth who smoke cigarettes was 21.8%, down from the FY97 rate of 27% and better than the target of 23%. Data for this measure are taken from the Vermont Youth Risk Behavior Survey (YRBS) which is conducted every other year (1995, 1997, 1999). We expect to see further declines in this indicator due to the efforts of the Tobacco Control Program at VDH.

7) *The percent of Women, Infants and Children (WIC) program families who use feeding practices that prevent Baby Bottle Tooth Decay (BBTD).*

Routine data collection about feeding practices began in WIC visits on January 1, 1999. Feeding

practices are assessed for each child at six weeks of age, six months of age, and at six month intervals until the child is weaned. Feeding practices information is based on national WIC risk criteria from *Inappropriate Use of Bottles* implemented January, 1999. As of November, 1999, this measure indicates 89.4% of active WIC infants and children were fed using practices that prevent BBTD. As this data indicate, the interventions for changing feeding practices appear to be successful. Thus, consideration is being given to altering this performance measure to reflect more fully feeding practices that affect child oral health.

8) *The percent of Vermont Maternal and Child Health (MCH) staff successfully completing cultural competency training*.

In 1999, 35 of the 35 newly hired MCH staff (100%) completed the first tier of cultural competency training, which has now been included in the orientation for all new VDH employees. This has been serving as our baseline performance objective for measuring training activities. The second tier of training has been developed and MCH staff have been scheduled to complete the training according to ongoing schedules. This performance measure will be refined in the next year to more fully reflect the training needs and the resultant effect on implementation in planning and service delivery.

9) *The degree to which an accessible comprehensive data system supports CSHCN policy making, planning, and activities*.

In the reporting year, some, but not all, CSHN staff obtained PC's with Microsoft Office which were networked within the statewide Health Department. Staff with PC's received basic training with MS Office, and those who felt they could utilize some of the more advanced features received more advanced training. As a result, several CSHN staff created and now maintain self-contained databases, in MS Access. These include a patient information database for children in the Cleft Palate/Craniofacial program, children in Child Development Clinic, children in the Cost Share Program, and children in the Respite program. Only the Child Development Clinic database is accessible by more than the creator of the program. In addition, the evolution of the Access database supporting the Hearing Outreach Project has been completed.

2.5 Progress on Outcome Measures

See ERP Form 12.

Our success in achieving over half of the performance measure targets resulted in an overall positive impact on the outcome measures. However, the rates of infant and neonatal mortality show an increase and the Department of Health's efforts to decipher the causes of these higher values continue. Rates for postneonatal and perinatal mortality continue to decline. Also, a decline in the child death rate was evident.

III. REQUIREMENTS FOR THE APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

The needs assessment process was largely supported by activities funded by the State Systems Development Initiative. The overall goal of this initiative is to support the development of an enhanced data infrastructure which will more efficiently support Vermont's efforts at assessment, planing, and evaluation for the MCH population. A specific activity of SSDI, has been the conducting of an assessment of the needs and service gaps of the MCH population by using core and developmental health status indicators as a framework. A significant outcome of the assessment is the identification of ten priority needs for Vermont's MCH population.

This needs assessment is viewed as a beginning framework on which to build an ongoing, comprehensive process of assessment, evaluation and planning for the public health of Vermont's women and children. The continuing assessment will articulate the strengths and needs of this population using a broad definition of health, which includes mental and social needs as well as physical health needs. The ongoing assessment process will define overall health care delivery capacity and gaps in services which are designed to address health, thus aiding the efficiency of planning and service delivery. The opportunities offered by the event of a needs assessment will be used to further collaborative planning efforts within the Department of Health and with other statewide and community based health organizations. The findings from the ongoing assessment will not only be reported in future Title V Continuation Grant applications and SSDI reports, but also in appropriate internal program assessment and planning documents.

3.1.1 Needs Assessment Process

Several standard major data banks were used for the needs assessment which were relevant to all levels of the pyramid. In general, direct health care and enabling services were measured by program service level data, such as WIC, Healthy Babies, and CSHN. Population based and infrastructure building data was best evaluated by statewide data sets, such as vital statistics, Youth Risk Behavior Survey (YRBS), Pregnancy Nutrition Surveillance System (PNSS), birth certificates and hospital discharge data and Medicaid. Program data such as WIC and Healthy Babies also provides proxy data for evaluation of MCH populations statewide. Certain publications which compile data on parameters describing the broad determinants of

health were also used, such as the Social Well Being of Vermonters, the Community Profiles, the Vermont Health Action Plan, 2000, and the Vermont Health Action Plan, 2000. Other reports on specific disease conditions or service delivery systems were used, such as the Vermont Health Care Quality Report and the Recommendations for the Management of Diabetes in Vermont (both prepared by the Vermont Program for Quality in Health Care in collaboration with VDH) and the 1996 Physician's Survey.

The available data sources have been improving in their usefulness, completeness and applicability over the past several years. Improvements such as the linking of the birth certificates and WIC data (via PNSS) add to the efficiency of health assessment and planning. Other key linkages have been made available are those between birth certificates and infant deaths or birth certificates and hospital discharge data. Individual program data capability has also been improved, enabling the linkage of Healthy Babies program data with the program's outcome objectives.

Many present weaknesses in the MCH data systems will be largely addressed by the SSDI grant activities. SSDI planing is directed achieving at the overall goal of a "data warehouse", which will allow the extraction of MCH data from multiple sources and make it available for standard reports, monitoring of progress throughout the planning year, special queries by users, analysis for trends, problem identification, and program evaluation. Within the SSDI framework, other systems issues will be addressed by the ongoing efforts to improve linking assessments of health status (such as oral health screening and application of sealants or preventive care utilization) to Medicaid records. A more comprehensive link between Medicaid, birth certificates, and Health Department client records needs to be developed. For Medicaid clients who are not on Health Department programs such as WIC or Healthy Babies, direct linkages to birth certificates need to be strengthened. A statewide immunization registry is being developed using the birth certificate as a base. Within the next year, the Pregnancy Risk Assessment Monitoring System (PRAMS) will begin in Vermont. The data from this surveillance system will add greatly to the overall bank of information on the MCH population, by providing a tool to collect data on such behaviors as breastfeeding, maternal alcohol consumption and tobacco use, etc.

A general weakness inherent in much of Vermont's data comes from the phenomenon of small numbers. Since Vermont's population base is relatively small and breakdown by community

or population area creates an even smaller population base, it is difficult to assess true trends and year to year variability. SSDI is supporting planning activities to devlop new tools to address this issue in data analysis. Another weakness is that hospital discharge data contains no individual identifiers, making it difficult to fully assess measures such as length of stay, readmission rates, etc. In addition, Vermont's birth defects system presently relies on use of existing data sets. The potential utility of a more comprehensive active surveillance system is being explored.

The actual process of determining the ten priority needs of the MCH population would not have been possible without the strong collaboration within various divisions of the Health Department and key regional and locally based organizations. The following groups were included in the specific assessment and evaluation process: the Vermont Department of Health's Divisions of Health Improvement and Community Public Health, the Minority Health Community Advisory Committees, locally based MCH Coalitions from across the state, and the Area Health Education Centers. These groups have close ties with other health and social service organizations, thus allowing for a broad base from which information was gathered. For example, the MCH coalitions, organized by the Community Public Health Healthy Babies system of care, consist of representatives from local hospitals, parent child centers, social services, insurance companies, social welfare, home health agencies, etc. Thus, the connections with key groups allowed for a wider tie with many community groups who have valid information on the health status and needs of the MCH population.

Throughout the past year, informal feedback from these groups and formal communications within the VDH enabled the creation of a list of key indicators for use in assessing the health needs of Vermont's MCH population. This listing was formed within the framework of the Title V core and developmental indicators. The listing was then "described" by choosing relevant data from the VDH's various data sets, which enabled comparison with national trends and Healthy People 2010 objectives. This general listing was distributed to the above mentioned community and VDH organizations for "voting" as to the ten priority MCH needs on which to focus Title V efforts. Feedback from the community groups and the CSHN processes was then summarized and given to a steering committee of key health department planners for a final discussion and "vote". The final process, as was the case for the year long planning process, was linked to key VDH planning activities, the Health Status Indicators, and the Performance

Measures. For example, the links between the present needs assessment listing, the ten priority needs from five years ago, the Vermont Action Plan, and the Healthy Vermonters 2010 process are illustrated in the following table.

Comparison of Selected MCH Planning Activities
June 2000

2001 Title V Needs Assessment Priorities	1996 Title V Needs Assessment	Vermont Action Plan 2000	Health Vermonters 2010
1. Medical home for all children	Childhood immunization rates increased	-Increase percent of children receiving well-child care. -Improve cultural awareness among health care providers -Ensure an adequate supply of health care providers	-Increase percent with health insurance -Increase immunization rates -Increase percent with a specific source of primary care
2. Successful CSHCN transition to adulthood		-Improve systems to help families cope with crises.	
3. ETOH and tobacco use	Maternal and youth ETOH Maternal and Youth tobacco	-Decrease maternal smoking -Increase healthy behavior in youth	-Increase counseling about alcohol/tobacco -Decrease binge drinking
4. Dental home	BBTD feeding practices Sealants	-Assure an adequate supply of dentists	-Increase percent using the oral health care system
5. Fetal and infants deaths will be reduced	Reduce LBW Reduce SIDS	-Further reduce Vermont's infant mortality rate	-Reduce infant death -Reduce LBW
6. Injuries and unnatural deaths in childhood will be reduced	Reduce child abuse Reduce MVA's	-Increase assets and opportunities for adolescent to engage in health behaviors -Raise awareness of depression in teens	-Reduce child abuse -Increase safety belt use -Reduce alcohol related MV deaths
7. Reduce maternal child exposure to environmental hazards		-Promote use of folic acid -Reduce exposure to ETS -Reduce lead poisoning	-Increase percent of homes tested for radon
8. Reduce unintended and adolescent pregnancies		-Increase assets and opportunities for adolescent to engage in healthy behaviors	-Reduce teen pregnancy
9. Home and		-Improve systems to help families	

2001 Title V Needs Assessment Priorities	1996 Title V Needs Assessment	Vermont Action Plan 2000	Health Vermonters 2010
community based services for CSHCN		cope with crises.	
10. Reduce childhood overweight and obesity		-Increase involvement in exercise, sports and physical activity.	-Reduce overweight and obesity -Increase physical activity
	ID of hearing loss		

3.1.1 Needs Assessment Process for CSHCN

In addition to more formal data-based information, the needs assessment for the CSHCN population utilized a thorough and collaborative process of gathering qualitative and semi-quantitative input from a broad range of families of CSHCN. The process was quite open-ended in scope. The recommendations, however, demonstrate that all four levels of the "pyramid" were considered and addressed by the families participating in the surveys and focus groups.

CSHN contracted and collaborated with Parent to Parent of Vermont, a statewide, parent-run organization supporting CSHCN and their families. The overall method included both a statewide, written survey of families, and focus groups held at statewide locations. A consultant and trainer in the area of consumer-driven programs for families who have children with special needs was hired to facilitate the process; the process was overseen by the CSHN management team (CSHN director and supervisors) and the Parent to Parent Board of Directors Evaluation Subcommittee.

The process sought and achieved input from a much wider population of families than those traditionally served by CSHN programs. Questionnaires were mailed to 8,000 Vermont families of CSHCN, including families known to Parent to Parent, CSHN, the Vermont Federation of Families for Children's Mental Health, the Vermont Epilepsy Foundation, Vermont Parent Information Center, and the Down Syndrome Network. In addition, each of the state's 60 special education coordinators were asked to distribute at least 50 questionnaires to their students' families, with additional forms sent to those districts where focus groups were to be held. As the mailing lists were confidential, no unduplicating of mailings was possible. Responses were returned from 138 (of 261) towns; families responding reported about 100 different diagnoses. 404 questionnaires were returned. 169 family members attended focus groups which were held at five sites around the state. An additional 15 families participated in extended telephone interviews which focused specifically on the services provided by Parent to Parent. Parent to Parent also conducted focus groups specifically seeking input about home based services for CSHCN such as respite, personal attendant care, and extended in-home nursing care. Data from the surveys was

entered using Excel spreadsheets. Qualitative responses from 200 of the 404 surveys were entered as well.

Five two-and-a-half hour focus groups were held. Everyone receiving a survey was invited to attend a focus group; reservations were necessary to limit the participation to a workable size. Dinner was provided. A recorder attempted verbatim notes. Discussion was framed by the following questions:

- What made you decide to come to this meeting?
- What services have you found helpful to your child and family?
- What services have not been helpful?
- If you had a magic wand and could have any services you wanted, what would you wish for?
- How has Parent to Parent been helpful to you and what do you wish it offered?
- How has CSHN been helpful to you and what do you wish it offered?
- How have your strengths been utilized and how might they be better utilized?

What feedback do you have on this process?

After the collection of input from families and the data entry described above, the consultant began a lengthy process of summarizing the findings and recommendations, with cycles of feedback to the Parent to Parent and CSHN overseeing committees, and then to a final work group. The work group was comprised of families who were "experienced" in the system of care for CSHCN and who were familiar with Parent to Parent and CSHN programs as well. The final report has been disseminated widely, posted on the Parent to Parent website, and a summary has been published in the Parent to Parent newsletter. The ensuing steps include: Reconstitution of the CSHN Advisory Council as a Parent Advisory Council; establishment of work groups within Parent to Parent and CSHN (and the division and department in which it resides) to define actions and timetables; further entry and analysis of the qualitative elements of the surveys (to be funded by a foundation grant). Some elements of the input include information of particular interest to other parts of the system, such as special education and Part C Early Intervention.

Limitations: This study was based on a relatively small sample of the total population of Vermont families who have children with special health needs, which is estimated to be about 25,000, or 18% of the total population of children birth to age 18 years. Surveys and focus group invitations

were mailed to a very diverse population of families; however, the families were only those already known to one or more agencies serving or advocating for CSHCN. There was no self-identification of families from a population-wide survey, such as will result from the SLAITS survey.

A second specific needs assessment process was targeted at a population of children who have historically not been served by the state's CSHN program, children with diabetes. Again, Parent to Parent of Vermont was engaged to perform a family-centered needs assessment; in turn, Parent to Parent contracted with two pediatric psychologists with training, experience and interest in the areas of diabetes in children and in family-centered care. To define the population, all primary care physicians caring for VT children were contacted to ask them to delineate the number of children with diabetes for whom they provide primary care. Recruitment of families occurred through posting of fliers in physician offices, mailing fliers to all families with children with diabetes followed at FAHC and Dartmouth, and a mailing distributed through diabetes educators. Three focus groups were held around the state, and nine parents who were unable to attend a focus group were individually interviewed. In addition, information was gathered from formal and informal support group attendees. Health care providers were also interviewed, including five primary care physicians who self-reported caring for more than five children with diabetes, and physician and nurse staff of the FAHC and Dartmouth diabetes clinic programs.

Finally, Vermont is one of six states participating in the MCHB-funded project, Monitoring and Measuring. As a participant, Vermont is analyzing the existing data, and describing further data that needs to be developed, to monitor and measure the six performance outcomes that are part of the Health People 2010 effort. Definitions of marker indicators are evolving for the six outcomes, and will aid Vermont in the ongoing needs assessment process.

3.1.2 Needs Assessment Content

The following is a description of the health status of Vermont's MCH population. For a description of presently available services and planning efforts to address service gaps, see the discussion of performance measures in the annual report (Section 2.4) and the Annual Plan

(Section 4.1).

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

An overview of the key MCH health indicators is summarized in the following table. A brief discussion of the content in the table is offered in this section. For more detailed discussions the health status, services, and service needs of the MCH population, please see also Program Capacity (Section 1.5.1.2), Progress on Annual Performance Measures (Section 2.4), Progress on Outcome Measures (Section 2.5), Program Activities Related to Performance Measures (Section 4.1) and Current Priorities (Section 1.4).

Health Status Data for MCH Population
Vermont Data and HP 2010 Goals

Indicator	Vermont	HP 2010 Goal	Indicator	Vermont	HP 2010 Goal
Intended pregnancies	No data	70%	VLBW born at Level III Centers	83%	90%
Teen pregnancies	21.7/ 1,000	46/ 1,000	Reduce cesarean among low-risk, no prior cesarean	10.8%	15.5%
Sexual intercourse before age 15	91%	88%	Reduce cesarean among low-risk, prior cesarean	59.2%	63%
Blood lead levels in children	5.7%	0	LBW	6.6%	5.0%
Deaths from motor vehicle crashes, children ages B-14 yrs	1.7/ 100,000	4.2	VLBW	1.4%	0.9%
Residential fire deaths, children B-4	2.8/ 100,000	0.6	Preterm births	8.2%	7.6
Drownings, all ages	3.4/ 100,000	0.9	Abstinence from alcohol in pregnant women	90.5%	94%
Maltreatment of children	15.9/ 1,000	11.1	Abstinence from cigarettes in pregnant women	82.1%	98%
Infant deaths	7.2/1,000	4.5	Cigarette use by adolescents	34%	16%
Child deaths ages 1-4	38.2/ 100,000	25	High school seniors binge drinking	43%	11%
Adolescent deaths ages 15-19	97.2/ 100,000	43.2	Dental sealants, 8 year olds	43%	50%
Early and adequate prenatal care	67.5%	90%			

Although Vermont's indicators show many areas in which the MCH population ranks favorably with the national goals, there are areas of need that will respond to enhanced efforts from both the direct health care and public health sectors.

Overview for Pregnant Women, Mothers, and Infants

Approximately 88% of women were seen for their pregnancies in the first trimester, which is near to the national goal of 90%. However, only 70% appear to have received early and adequate care as defined by the Kotelchuck Index. Vermont's 1998 low birth weight percent was 6.6, as compared to a national figure of 5.0%. In addition, the percent of very low birth weight is 1.4, compared to 0.9% nationally. Data show Vermont's preterm births to be 8.2%, which is near to the national goal of 7.6%. The rate of cesarean deliveries among women with no prior cesareans is 10.8%, compared with the national goal of 15.5%. Vermont continues its efforts to enhance access to care for pregnant women and infants. Although virtually all of Vermont's pregnant women are eligible for insurance (whether private or Medicaid), community based systems, such as Healthy Babies, of enhancing access to care and overall utilization continue to be strengthened. Programs such as those out of the Vermont Program for Quality in Health Care provide support to enhance systems of assessment and quality improvement for health care delivery.

Data from the Healthy Babies program indicates that 90.5% of pregnant women report abstaining from alcohol which nears the national goal of 94%. Birth certificate data indicate that 82% of women report abstention from cigarettes during pregnancy, versus the national goal of 98%. More sophisticated data will be forthcoming with the advent of PRAMS. In addition, efforts such as the smoking assistance program from the University of Vermont (in collaboration with VDH) provide support to individuals for the overall effecting of this measure.

Overview of Children and Adolescents

The adolescent pregnancy rate of 21.7/1,000 compares favorably with the national goal of 46/1,000. Ninety-one percent of Vermont's teens (under 15 years of age) report sexual abstinence, somewhat higher than the national goal of 88%. About 34% of adolescents report

cigarette use, far higher than the national goal of 16%. Also, 43% of high school seniors participate in binge drinking behavior, again, higher than the national goal of 11%. These indicators continue to be measured by such systems as YRBS and individual program data. Overall, collaborative efforts drawing together services from health, mental health, and social work are being strengthened to support the development of children and youth assets. Examples of specific efforts to address these issues are being implemented out of the Office of Tobacco Control and the New Directions Program within the Office of Alcohol and Drug Abuse Prevention.

Eighty-nine percent of Vermont's two year olds have completed the basic childhood immunization series. The development of an immunization registry will greatly enhance public health system's ability to track immunizations and improve efficient delivery of primary care services. The rate for hospitalizations for asthma among children less than five is 4.1. Although this rate is lower than the national targets, respiratory diseases are the leading reason why children why children under 18 are hospitalized in Vermont. Of the children aged 1 to 5 years who were tested for lead poisoning, 5.7% had an elevation, compared to the overall goal of zero. The Childhood Lead Poisoning Prevention Program (CLPPP) continues collaborative, community based efforts with housing and health personnel to effect this measure.

Data from available oral health surveys indicate that 43% of eight year olds received dental sealants, lower than the national goal of 50%. Efforts continue to develop community and statewide service systems to enhance the delivery of oral health services within a dental home. Also, planning will be directed at increasing the ability to measure dental health service utilization and payment methods.

Vermont infant deaths occur at a rate of 7.2/1,000 live births, compared with the national goal of 4.5/1,000. The child death (children aged 1-4 years) rate is 38.2, versus the national goal of 25. Adolescent deaths (ages 15-19) occur at a rate of 97.2 and the goal nationally being 43.2. Drownings for all ages occurs at a rate of 3.4 per 100,000 in Vermont. The national target is 0.9. (Vermont data for individual age groups are unreliable because of small numbers.) Residential fire deaths of young children (ages birth to four years) occur at a rate of 2.8/100,000. Nationally, the

target is 0.6/100,000. The rate of deaths from motor vehicle crashes is 1.7/100,000; the national goal is 4.2/100,000. Data show that reported cases of maltreatment of children occur in Vermont at a rate of 15.9/1,000. The national goal is 11.1/1,000. A variety of programs are being strengthened to address these overall issues of child mortality. Perinatal systems of care are being linked with community based early education and social services (as in the Healthy Babies "expansion" funded by the Commonwealth Fund). The Child Fatality Review Committee continues in this assessment and overview of specific childhood deaths. The newly established Injury Prevention Program is continuing with a needs assessment of injury related morbid and mortality for all age groups.

3.1.2.2 and 3.1.2.3 Direct Health Care Services and Enabling Services for the MCH Population

Welfare Restructuring

Vermont's Welfare Restructuring Project (WRP), the nation's first statewide demonstration of time limited welfare, began on July 1, 1994, following receipt of federal waivers in April, 1993 and the General Assembly's enactment of Act 106 in January, 1194. As a means to achieving several important goals, in particular the markedly and measurably improved well-being of children and families, WRP seeks to accomplish the following: 1) Make dependence on ANFC benefits transitional, 2) Strengthen incentives to work, 3) Promote good parenting and positive role modeling, 4) Form a partnership between ANFC parents and the state, 5) Serve families according to three sets of rules. These three sets of rules define the subgroups through which families receive services. Group 3 enrollees are subject to all provisions of WRP, including the time limits and requirements to accept subsidized employment. Group 2 enrollees are subject to all provisions of WRP except the time limits and requirement to accept subsidized employment. Group 1 enrollees are subject to traditional ANFC policies. Since the implementation of WRP, data indicate that increased numbers of ANFC parents have entered the work force, are earning more than pre-WRP ANFC earners, and are less dependent on ANFC benefits or have left the rolls altogether. Between June, 1994 and July, 1999, the number of families receiving ANFC declined 34%, from 10,006 to 6,594 and the number of ANFC recipients declined 37% from

28,086 to 17,838. During the same period, the proportion of the case load employed grew from 18.5% to 29.%. Among those families that include a working family member and remain eligible for ANFC benefits, average monthly earnings grew by 44% (from $329 to $474 per month). Beginning in July, 2001, Vermont's demonstration project will be incorporated into the statewide implementation of national welfare reform policies and requirements.

Availability of Care

Availability of care remains a concern among Vermonters. While the state has proactively developed programs that have guaranteed a wide access to insurance coverage resulting in more than 93% of its citizens currently being covered, there remains access issues across the state that are not directly related to insurance.

Vermont is ranked as among the most rural of states, and 13 of its 14 counties are either entirely or partially designated federal Health Professional Shortage Areas (HPSAs). Chittenden County is the only county with no HPSA designation. It is home to the state's only tertiary care center, which is also its largest hospital, Fletcher Allen Health Care. FAHC is the base for practice of 531 (or 37.6%) of the state's total 1,410 physicians.

Of these 1,410:
234 (17%) are Family Practice physicians, 158 (11%) practice Primary Care Internal Medicine, 100 (7%) are Pediatricians, and 62 (4%) are Obstetricians and Gynecologists.
In specialty care: 58 (4%) are Anesthesiologists, 82 (6%) practice Emergency Medicine, 124 (9%) focus on Internal Medicine Specialties, 38 (3%) are General Surgeons, 53 (4%) are Orthopedic Surgeons, 30 (2%) practice other surgery, 142 (10%) specialize in Psychiatry, 66 (5%) are Radiologists, 43 (3%) are Pathologists, and 220 (16%) are in other specialized categories.

In all of these categories, 304 are over the age of 55, indicating an on-going problem as retirement becomes a significant factor that can have a dramatic effect on any community. With 21.5% of the physician population nearing retirement age or planning to retire there is an increased pressure on other physicians to take on additional patients. In most counties this is not a feasible long-term

solution. In others, it is simply not possible. Essex County for example has only one primary care physician, serving a population of more than 6,000 people.

Like physicians, dentists are also in short supply. The state currently has 347 dentists practicing. Of those, 113 (or 33.7%) practice in Chittenden County. Again, some counties such as Essex and Grand Isle have a single practitioner, and neither county has any specialty care such as oral surgery, endodontics, periodontics, or prosthodontics.

There are a total of 299 advanced practice nurses in Vermont. Of these, 201 (67%) are Nurse Practitioners, 34 (11%) are Certified Nurse Midwifes, 36 (12%) are Clinical Nurse specialists, and 38 (13%) are Certified RN Anesthetists. Of the 299, 187 are working in primary care and the remaining 112 are in specialty care. As with the physicians and dentists, the majorities are concentrated in one area, Chittenden County, where 108 (or 36.1%) practice. As is consistent with national trends, Vermont is presently experiencing a nursing shortage that is expected to worsen as the presently employed nurses retire and fewer nurses enter the profession. The average age of nurses in Vermont is approximately 46 years, with fewer young people applying to schools of professional nursing.

Other practitioners, dietitians, social workers, audiologists, and occupational or physical therapists are proportionally scattered much the same as the physicians, dentists, and nurses in the state. Again, the greatest need remains in the rural parts of Vermont.

While Vermont is not exceptionally large geographically there are barriers to care that affect travel. Obviously, in a rural New England State, inclement weather, especially snow (the median snowfall each year is 112 inches) through several months of the year can make travel difficult or impossible. Also, with nearly 11% of the total population living below federal poverty levels and another 14% at or below 200%, transportation, child care, and time away from the job play heavily in decisions to seek a medical professional.

There is a dedicated Coalition of Clinics for the Uninsured, which operates in nine sites around

the state. These free clinics, staffed almost exclusively by medical professional volunteers provide routine healthcare, immunizations, management of chronic illnesses, referral to specialty and complementary health care, and assistance in enrolling clients in government insurance and other entitlement programs. The Coalition's over-arching goal is to provide free care to those who fall through the cracks, i.e., that do not qualify for one of the state's entitlement programs and who are not privately insured. The Coalition is also the recipient of a Robert Wood Johnson grant which funds outstationing specialists whose job is to work individually with patients to assess their eligibility for other social welfare programs that can improve the individual or family's quality of life.

There are only two Federally Qualified Health Centers in the state, one of which is located in the urbanized low income area of Chittenden County. This FQHC, the Community Health Center in Burlington, is currently undergoing renovation to create a low-cost dental clinic and a mental health facility at its present location in addition to primary care. The second is a network of four clinics located in Caledonia and Essex Counties. Both work cooperatively with the Coalition and have collaborative relationships with their local hospitals, the Vermont Department of Health's district offices and programs such as WIC. Likewise, networks of 22 rural health clinics provide similar services to areas most in need.

Health Planning

The Coalition, the FQHCs, as well as the state's Primary Care Association, Dental and Medical Societies, the Vermont Hospital and Health Systems Association, the Office of Health Access (Medicaid), University of Vermont Medical School, the Vermont Recruitment Center, and the Area Health Education Centers participate monthly in the Primary Care Steering Committee (PCSC) sponsored by the State Office of Primary Care and Rural Health (OPC/RH). This group provides leadership in monitoring and assessing health policy development and its impact on primary and specialty care programs as well as mental health and oral health programs that serve traditionally underserved and vulnerable populations.

A chief goal of the PCSC is to identify communities and populations within the state that lack

access to preventive and primary care services and to develop strategies to improve access and quality of care for these Vermonters. To do this, the Committee expands communication and collaboration among existing provider agencies and community-based organizations by encouraging networking and offering technical assistance and supportive strategic planning within the targeted communities. The program also works with local providers to ensure that they have sufficient support systems in place to provide the caliber of care needed and the resources to offer culturally appropriate linkages and educational opportunities for their patients.

This past year has been an active one in terms of long-term health planning. The Department of Health has worked diligently to create the *Vermont Health Plan: A Call to Action, 2000.* To come up with this broad-based plan, the Department sought extensive public input. Public health nurses conducted more than 3,000 face-to-face interviews, and the *Plan* incorporates comments and suggestions from health professionals, educators, business owners, town and state officials, school administrators, legislators, and private citizens. The goal was to ensure that the document would reflect the actual needs of Vermonters while also emphasizing the need for self-involvement in one's health care. The *Plan* calls for people to take greater responsibility for improving their own health and encourages adopting healthier behaviors. It also places more emphasis on cost-effective prevention measures within the health care system while at the same time calling for an increase in quality improvement and access to medical services for all Vermonters.

Related to this year's *Call to Action*, the Department of Health has engaged in a lengthy process that has included 88 community-based organizations and more than 210 providers and consumers to select health outcome measures for a ten-year plan, *Healthy Vermonters 2010*. The final version will be released mid-year. Priorities were modeled using the federal guidance related to the *Healthy People 2010* national health care plan, and includes strategies for promoting healthy behaviors, improving healthy and safe environments, reducing the spread of specific diseases and disabling conditions (including cancer, stroke, heart disease, HIV/AIDS, diabetes, and arthritis, among others). There are also components addressing tobacco and alcohol reduction, as well as

substance abuse, family planning, maternal and child health, mental health and respiratory disease.

Dental Care

Also this year the legislature allocated $400,000 in new funding to increase access to dental care for Medicaid and Dr. Dynasaur recipients. In addition, also for the first time, the legislature included a $100,000 appropriation for the recruitment and retention of dentists in Vermont. A key component of that effort is the creation of a dental loan repayment program similar to the existing medical loan repayment program.

The $400,000 earmarked for new dental initiatives was granted to a total of 14 dental clinics, hospitals, and private practitioners after a statewide solicitation for proposals. In total, the Department of Health received 25 applications for over $2.1 million in proposed services.

The Office of Minority Health supported a study through the University of Vermont that resulted in the creation of *Healthcare Issues Affecting Minority Groups in Vermont*. Strategies to address the problems identified by this study are presently being developed.

Availability of Services Physicians

• In 1996, 98 percent of office practice sites statewide (there may be more than one for each provider) expected to continue operating for the next year, and 95 percent were accepting new patients.

• One or more primary care sites were expected to close within the next year in six counties: Addison, Chittenden, Franklin, Rutland, Washington and Windsor.

Percentage of Practice Sites that Accept New Patients

Practice Specialty	Any New	Medicaid	Medicare
PRIMARY CARE			
obstetrics/gynecology	100%	98%	98%
pediatrics	98%	98%	NA
family practice	89%	81%	85%
internal medicine (general)	87%	78%	83%
SPECIALTY CARE			
surgery (other)	99%	99%	99%
other specialties	98%	96%	98%
surgery (general)	100%	98%	100%
internal medicine (specialty)	96%	96%	96%
psychiatry	95%	78%	91%

Medicaid & Medicare

• Medicaid enrollees were accepted as new patients at 86 percent of primary care sites, and 93 percent of specialty care sites around the state.

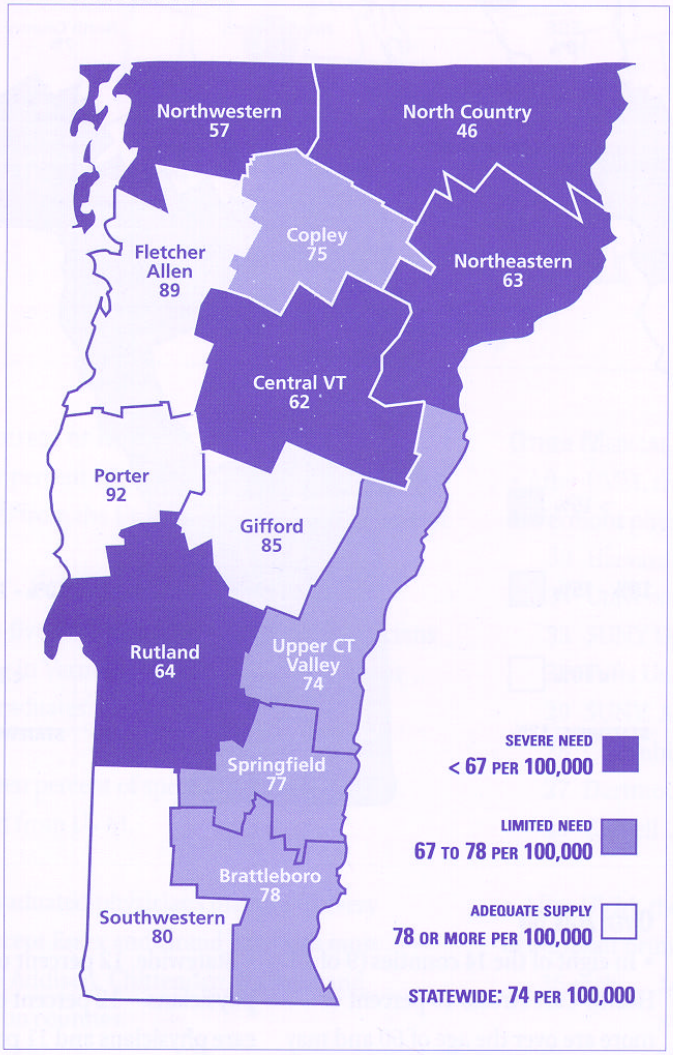
• Medicare enrollees were accepted as new patients at 87 percent of primary care sites and 96 percent of specialty care sites around the state.

• Ninety-five percent or more of all physician specialties accept new patients—except family practioners (89%) and general internists (87%).

• Psychiatry and general internal medicine are least likely to accept new Medicaid patients.

Physicians by Locality

Primary Care Physician to Population Ratio, by Health Care Area



County Trends 1994 to 1996

• Since 1994, the primary care physician to population ratio has changed from severe to limited in Addison and Caledonia counties, and from limited to adequate in Lamoille County.

• The loss of three FTEs since 1994 translates to a decrease of 22 percent in Orleans County.

Specialists

• In 1996, there were 875 specialists, or the equivalent of 623 full-time specialists. This is up from 1994, when there were 736 specialists, or the equivalent of 556 FTEs.

• Statewide, Vermont has an average of 106 full-time equivalent specialty physicians per 100,000 population, compared to a suggested range of 78-95 per 100,000.

BY LOCALITY Physicians

PRIMARY CARE PHYSICIANS

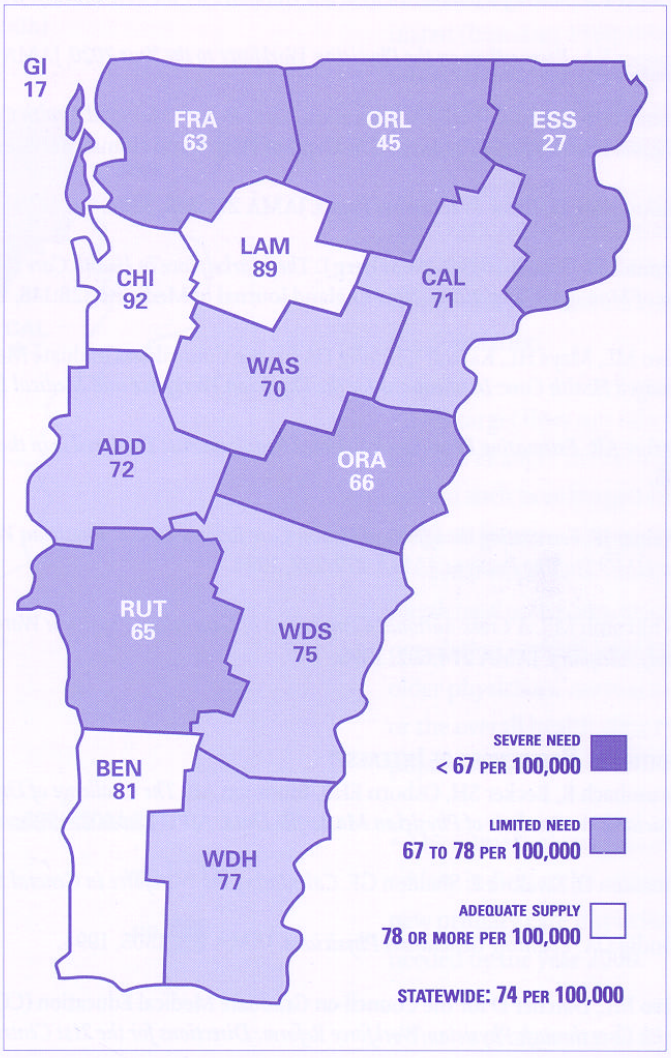
• Six counties (five Health Care Areas) have a severe shortage of primary care physicians, compared to eight counties in 1994. Three counties (four Health Care Areas) have an adequate physician-to-population ratio, compared to only two counties in 1994.

• Statewide, Vermont has an average of 74 full-time equivalent primary care providers per 100,000 population, compared to 70 per 100,000 in 1994. The suggested average is 78 per 100,000.

• The average per 100,000 population as compared to the suggested average rate for each of the primary care specialties is:

	VT AVG.	SUGG. AVG.
Family practice	31	33
Internal Medicine	22	28
Ob/Gyn	9	9
Pediatrics	13	11

PRIMARY CARE PHYSICIAN TO POPULATION RATIO, BY COUNTY



Physicians AFFILIATIONS

PHYSICIANS, BY SPECIALTY WORKING WITH MIDLEVEL PROVIDERS

	'94	%	TOTAL: 1204	'96	%	TOTAL: 1384
anesthesiology	55%	...	51	73%	....	60
emergency medicine	35%	...	69	67%	....	81
internal medicine specialists	17%	....	94	40%	....	124
PRIMARY CARE:						
family practice	43%	...	199	63%	....	227
general internal medicine	39%	...	147	57%	....	155
obstetrics/gynecology	39%	...	61	40%	....	63
pediatrics	38%	...	86	47%	....	90
psychiatry	13%	....	130	30%	....	152
surgery (general)				32%	....	50
surgery (other)				34%	....	74
all other specialties	*15%*	.....	*251*	*24%*	.....	*308*

- Forty-four percent of Vermont physicians report affiliation with nurse practitioners or physicians' assistants.

- Primary care providers are more likely than specialists to work with mid-level providers (56% versus 36%).

- Nearly three-quarters of anesthesiologists work with a physicians' assistant or advanced practice nurse.

- More than half of physicians in emergency medicine, family practice and general internal medicine. work with a physicians' assistant or advanced practice nurse.

MIDLEVEL PROVIDERS:

- advanced practice nurses (APN) including nurse practitioners (NP)

- physicians' assistants (PA)

3.1.2.2 and 3.1.2.3 Direct Health Care Services and Enabling Services for CSHCN

Priority Needs Summary:

- Direct Services: There is an urgent need for a greater capacity for a spectrum of home and community-based supports, from in-home high-tech nursing, to personal care services to respite, to flexible family funding for services and equipment, that lie outside those traditionally considered medically necessary.

- Enabling Services: There is a need for enhancement of the ability of primary care providers to function as Medical Homes, thereby improving comprehensiveness, collaboration, coordination, information, and advocacy for CSHCN and their families, across all systems of care.

Financial Barriers to Primary/Preventive Care for CSHCN

Currently there are few barriers to primary care for children, including CSHCN. The percentage of children who are insured is above 90%. Statewide, about 50% of children have Medicaid as a primary or secondary insurance, with its excellent coverage of primary care. The percentage of children enrolled in Part C and/or CSHN who have Medicaid as an insurer is even higher, about 70%. One reason for this higher coverage is that the Disabled Children's Home Care Program, the TEFRA option, offers Medicaid coverage for children with severe disabilities, regardless of parental income.

On the other hand, some commercial indemnity insurances, including one of the options for state employees, Choice Plus, does not offer coverage for primary care past the second birthday.

CSHCN Focus Group/Interview/Survey Needs Assessment Data

Families did not identify financial access to primary care as an area of need.

Other Sources of Needs Assessment Data

See Performance Measures #11, #12, and #13. In addition, the Part C program (administered within CSHN) collects insurance status information on enrolled infants and toddlers.

Role of the CSHCN Program in Addressing Areas of Need

Under current policy, CSHN specifically does not provide financial coverage of primary and preventive care for CSHCN. However, as above, this does not appear to be a significant gap, nor one prioritized by parents of CSHCN.

In addition, CSHN plays direct and indirect roles in facilitating Medicaid eligibility. The enrollment process identifies potential income eligibility for Medicaid and families are encouraged to apply. Clinical CSHN and Part C staff review the possibility that a child may be eligible for the TEFRA option. CSHN and Medicaid fund Parent to Parent to provide outreach to families with CSHCN about enrollment in Medicaid.

Financial Barriers to Specialty/Sub-Specialty Care for CSHCN

The extent of health insurance, and particularly Medicaid, coverage for CSHCN also reduces financial barriers to specialty/sub-specialty care for CSHCN. (See above discussion.) However, with specialty care and rehabilitative care (see Availability/Capacity below), financial access "on paper" does not always correlate with true access, because of limitations in networks, medical necessity determinations, and the effect of low reimbursements on the willingness of providers to care for CSHCN.

CSHCN Focus Group/Interview/Survey Needs Assessment Data

See Availability discussion, below.

Other Sources of Needs Assessment Data

See Performance Measures #11, #12, and #13. In addition, the Part C program (administered within CSHN) collects insurance status information on enrolled infants and toddlers.

Because CSHN and Part C both have a role as a payer of last resort for these services, we are able to measure selective gaps in enrolled children's insurances, by the "safety net" payments that we make on behalf of children who have insurance (albeit inadequate), and those who do not have any insurance.

Role of the CSHCN Program in Addressing Areas of Need

Although not for primary care services, CSHN does function as a payer of last resort for specialty services for CSHCN (see Performance Measure #2). And, as described above, CSHN plays direct and indirect roles in facilitating Medicaid eligibility.

Financial Barriers to Habilitative and Rehabilitative Services for CSHCN

The extent of health insurance, and particularly Medicaid, coverage for also reduces some financial barriers to these services for CSHCN. (See above discussions.) However, the scope of these services needed by CSHCN often exceeds the scope of the stated benefits of insurance packages, particularly in areas of equipment and therapies.

CSHCN Focus Group/Interview/Survey Needs Assessment Data

Families expressed appreciation for the financial support which CSHN provided for needed medical/habilitative services. However, parents also emphasized that they would like the funding to be more flexible, for example, so that they could hire an aide in a non-public program or school, or select their own respite workers, or pay for alternative treatments. Some families with CSHCN are eligible for the "Flexible Family Funding" program offered by the Division of Developmental Services within the Department of Developmental and Mental Health Services. This program provides funding of up to about $1100 annually for families to use for respite and/or other kinds of needed supports, such as adapted tricycles, camperships to specialized camps, software, and other services which are not covered by traditional sources of health care financing. However, eligibility for this program is limited to individuals with documented mental retardation; in addition, children compete with adults with developmental disabilities, and waiting

lists are often long. It is not uncommon for a region's funding to be exhausted two or three months into the fiscal year.

Other Sources of Needs Assessment Data

As with Specialty/Subspecialty care above, please see Performance Measures #11, #12, #13. In addition, the Part C program (administered within CSHN) collects insurance status information on enrolled infants and toddlers.

Because CSHN and Part C both have a role as a payer of last resort for Habilitative and Rehabilitative services as well, we are able to measure selective gaps in enrolled children's insurances, by the "safety net" payments that we make on behalf of children who have insurance (albeit inadequate), and those who do not have any insurance.

Role of the CSHCN Program in Addressing Areas of Need

As with specialty/subspecialty services, CSHN does function as a payer of last resort for habilitative and rehabilitative services for CSHCN (see Performance Measure #2). And, as above, CSHN plays direct and indirect roles in facilitating Medicaid eligibility.

Under current policies, CSHN's opportunity to provide support as flexible as that recommended by families through the needs assessment process is limited. CSHN's annual respite budget of $120,000 is directed specifically for respite services (with the families as employers); in an effort to keep waiting lists to a minimum, CSHN plans its annual respite allocations to anticipate the numbers of families requesting respite, resulting in allocations of about $360 per child per year. For children with particularly intense needs or requiring respite workers with nursing training, there is the flexibility for higher allocations.

There are two activities, however, in the coming year to explore increased flexibility of funding.

1. The Medicaid Personal Care Services program is piloting an option that allows interested

families to function as the employer of the PCS care attendant, rather than having to work through a home health agency.

2. CSHN will explore the possibility of utilizing a portion of its respite care funding as match for a Medicaid Home and Community Based Services Waiver, enabling the funding to expand and to be used for a broader set of support services than those which are "medically necessary."

Availability/Capacity for Primary/Preventive Care for CSHCN

Please refer to discussions of the state's capacity for primary care for all children, above (sections 1.5.1.2 Program Capacity, and 3.1.2.1). There is generally excellent availability/capacity for primary care for children. However, the parents participating in the CSHCN needs assessment drew a striking contrast between the availability of primary care, and the availability of a "primary care medical home" for their children. A special area of need, and one not specifically "measurable", is the availability of Medical Homes for adolescents with special health care needs. The age at expected transition to adult primary (and specialty) care is not well defined for any children, but is especially difficult for adolescents who have chronic conditions that are usually considered "pediatric" conditions, as they enter adulthood. Anecdotes, but not data, are plentiful; for example, a CSHN medical social worker is currently working with a family to recruit a new PCP for a teenager with a severe disability and seizures who will be willing to coordinate the medical treatment recommended by multiple specialists.

CSHCN Focus Group/Interview/Survey Needs Assessment Data

"We had fifteen doctors, but not a 'home'"; this statement characterizes many comments, written and verbal, of parents participating in the needs assessment. In the survey, a primary medical home was defined as "a primary care provider who understands the regular and special needs of your child, coordinates medical care, answers questions, gives information, connects the family to community resources, and knows the family well." Fifty-eight percent (194 of 404) responded that they had a medical home. However, in the three focus groups where there was an opportunity to define and discuss in more detail the concept of a medical home only 17% (16 of 93 parents) said they had a medical home.

Other Sources of Needs Assessment Data

See Performance Measure #3. Over 90% of families enrolling in CSHN programs give the name of their child's primary care provider on the application. See also discussion about utilization of primary care "well child visits" among children who have Medicaid, elsewhere in this document.

Role of the CSHCN Program in Addressing Areas of Need

Strengthening the capacity of the primary care medical home for CSHCN has been chosen as one of the ten priorities for Vermont's Title V program. CSHN has helped to support and participate in two projects enhancing the ability of primary care to provide a medical home model practice, the MCHB-funded Rural Medical Home Improvement Project and the originally SSDI- and now Healthy Tomorrows Partnerships-funded "Whatever It Takes" project. In addition, CSHN has been a vocal participant in the development of the new Medicaid primary care case management model, "PC Plus", which was initially intended to enroll SSI recipients into Medicaid managed care, and has now expanded to include nearly all Medicaid "eligibles".

However, the challenge is to develop workable enhancements for primary care practices statewide. There are at least two works in progress:

1. Medicaid's PC Plus (primary care case management) is developing a "care partners" model to enable PCP's to provide more case management for enrollees (of all ages) who are eligible for SSI. CSHN continues to be part of the planning process. Title V's special relationship with Medicaid, through EPSDT and the opportunity for cost-based billing, offers an opportunity to expand case management for CSHCN in Medicaid.
2. CSHCN programs traditionally have built teams and supports around specialty care services. Our current CSHN staff are distributed regionally. Follow-up discussions to the CSHN needs assessment will address the question of whether CSHN staff should shift their affiliations from specialty towards primary care, and what the consequences and resources might be for such a

shift.

Availability/Capacity for Specialty/Sub-Specialty Care for CSHCN

A small state such as Vermont is particularly vulnerable to shortages in pediatric subspecialties. At this writing, for example, a pediatric geneticist has just been hired to fill a vacancy lasting 1 1/2 years; there has been no pediatric neurosurgeon for 6 months; the state's one pediatric neurologist has been part-time for over a year; there is no pediatric pulmonologist; there is a part-time pediatric endocrinologist. The consequences of such vacancies are that Vermont children have to travel out of state (and sometimes out of country, to Montreal, Quebec) to access needed pediatric subspecialists. In times of shortage, CSHN plays a particularly important role in continuing to support families in finding and accessing needed medical care, and an increasingly complicated role in coordinating care in the community when the specialist is completely unfamiliar with Vermont resources.

A second issue of capacity is the size of the network that is available to CSHCN when enrolled in managed care. Some of the managed care organizations insuring Vermont children have had provider networks that differ from the usual Vermont networks, especially when the MCO is based in another state. For example, Vermont linkages have typically been with Boston-based highly specialized tertiary care, but two MCO's have been based in New York state and have directed referrals to Albany.

A third issue, of immense concern, is the availability of mental health care. Although a covered benefit in all plans, there are several factors limiting the actual availability of services:

1. Not all child psychiatrists are enrolled as Medicaid providers because of the fee structure. One CSHN family learned that their child's therapist "might have to stop seeing him" when their child's coverage changed from the Medicaid managed care plan contracted to Kaiser Permanente, to the Medicaid PC Plus plan. Under the KP plan the therapist received the same fee as that paid for commercially-insured KP beneficiaries; the payment is much lower under

the PC Plus plan.

2. The Department of Developmental and Mental Health Services contracts with community-based "Designated Agencies" to provide long term mental health services to individuals (children and adults) with Medicaid. Although the capacity and training of the agencies in pediatric mental health services is growing, it has not kept pace with the need, as reported by families.
3. Vermont has experienced the national increase in the numbers of children diagnosed with autism spectrum disorders, for whom intensive, daily behavioral interventions are recommended. Agencies and programs have scrambled to address this growth in need, guided by the parent-led Vermont Autism Task Force. However, the personnel, the training, and the funding fall short of the need.

A fifth issue is discussed under the next heading, in the following paragraph.

CSHCN Focus Group/Interview/Survey Needs Assessment Data

"Families need support from people who are trusting, accessible, non-judgmental, and there are no 'power roles.'" "I wish that we had longer visits with doctors so that a feeling for our child could be developed." "[We need] immediate scheduling and information at times of stress." Perhaps *the* dominant theme in the focus groups and surveys was the need for "service providers who feel deeply and see clearly", an element when, compared to, e.g., distribution of FTE's, is intangible and less measurable, and yet is the most common comment from families. In the needs assessment that focused on children with diabetes, parents mentioned the need for the specialists to be accessible by telephone, to be knowledgeable about medical and developmental aspects of childhood diabetes, and to assist with diabetes-related problems in school and community settings. Parents also made specific recommendations (see below).

Parents also commented on mental health availability and capacity. There were three areas of comment:

1. Parents of children with mental health concerns emphasized the need for more assistance in crises.

2. Parents expressed the need for professionals who are skilled both in counseling and medical issues.
3. Parents expressed their frustration at being "blamed and shamed" by schools and the community.

Role of the CSHCN Program in Addressing Areas of Need

With respect to the vulnerability of Vermont CSHCN to shortages in subspecialty care, CSHN plays a role in connecting and supporting families who need to go elsewhere for care. In addition, CSHN is strengthening its ties with other New England tertiary care centers. For example, a more formal relationship now exists with certain Dartmouth specialty programs. Another example is the relationship with Children's Hospital (Boston) metabolic program; the program has always functioned as a New England center of excellence and consultation, but in the absence of a geneticist, the CSHN program has collaborated even more closely in the care of specific VT children.

To address the need for "providers who feel deeply and see clearly," parents recommended:

1. Providers should be trained in the family-centered approach, utilizing the knowledge gained in the Parent to Parent Medical Education Project.
2. Families should be included in all forums designed to implement systems change and improve service delivery.
3. Parent to Parent and The Vermont Parent Information Center should be strengthened as sources of information for families about services and resources.
4. With respect to diabetes care, parents recommended that other sources of information for families be developed (a resource notebook; mutual parent support; better collaboration with the American Diabetes Association, as well as improved psychosocial supports such as age-specific support groups and psychology consultation.

In response, CSHN intends to strengthen its relationship with Parent to Parent in its many supportive functions, professional and pre-professional training, mutual parent support through its

Matching program, and its critically important role as a source of information for families. In addition, CSHN plans to maintain its relationship with Parent to Parent as an essential voice in the assessment of needs of CSHCN and their families, through their broad contacts with families, well beyond those served directly by CSHN programs. (See 3.1.2.5 Infrastructure, below.)

Availability/Capacity for Habilitative and Rehabilitative Services for CSHCN

Coverage of habilitative and rehabilitative services is described above. However, Vermont, as elsewhere nationally, is experiencing shortages of pediatric providers of occupational therapy (OT), physical therapy (PT), speech therapy (ST), home based nursing, and personal (i.e., attendant) care services (PCS). In addition to the absolute shortages of providers, Medicaid is currently limited in its ability to enroll private practitioners of therapy, relying instead only on home health agency, rehabilitation agency, and hospital based therapists.

Families also express the need for more, and better trained, providers of respite care.

CSHCN Focus Group/Interview/Survey Needs Assessment Data

Respite care was a major concern of families, both in the general CSHCN needs assessment and the diabetes needs assessment. This finding is consistent with other studies of families with CSHCN. Indeed, the need for respite may be understated in the findings: "As a single, working parent…I have not had a day off to just stay at home and relax in about two years. I am physically drained most of the time, too tired to fill out this questionnaire any better." Parents noted both their need for a "break" from the intensity of care of the child with special needs, and the need to spend time alone with child--a break from their other constant responsibilities.

Parents also remarked on the lack of providers of "medically necessary" home care, PCS and nurses. (see next section for other sources of this data.)

Other Sources of Needs Assessment Data

PCS is a relatively newly-funded fee-for-service program for children who have Medicaid coverage. At this writing, over 600 children have been found to be eligible for PCS (through a

written application to a committee which determined medical necessity and allocates the number of hours per week of PCS). However, anecdotes about the inability to recruit and retain qualified PCS workers have been increasing, reported both by from parents and provider agencies. Parent to Parent held a series of focus groups (separate from the CSHCN needs assessment process) to gather information from parents about the shortages they were experiencing. In confirmation, Medicaid reviewed claims data which indicated that only about one-third of the allocated hours of PCS had been provided (as measured by bills submitted). Even allowing for a lag-time between service provision and billing, the data suggests that PCS workers simply cannot be found for the majority of allocated hours, hours which were deemed to be medically necessary for the care of children with disabilities.

With respect to shortages of OT, PT and ST, the Family, Infant and Toddler Project (FITP), Vermont's Part C program, is particularly aware of the inability of families in some areas to access recommended ST. For example, a toddler who was referred to FITP this spring was unable to have a ST evaluation by a therapist in their home region until next fall, and needed to go out of region for the evaluation. Because some therapists have hospital-based or center based practices exclusively, it is difficult in some regions to provide the recommended level of home-based early intervention.

Because CSHN and FITP are a payer of last resort, their budgets are a source of information about OT, PT and ST services for which CSHN and FITP dollars have been used to purchase services for Medicaid children when they use non-Medicaid providers. Even as Medicaid has expanded its income eligibility, this amount has remained high as families access non-Medicaid providers, by necessity or by preference.

Role of the CSHCN Program in Addressing Areas of Need

The Vermont Title V program has chosen the need for home and community-based services for

CSHCN as one of the ten priority needs.

With respect to PCS, the CSHN director is participating in planning activities within Medicaid to address shortages. As mentioned above (under Financial Barriers to Habilitation and Rehabilitation Services), Medicaid has agreed to offer parents the option of being the employer of record for their child's PCS worker. Medicaid will contract with a payroll company, to be chosen competitively, to manage the paperwork and payroll. Medicaid will also contract with a non-profit agency to provide statewide guidance to families wishing to pursue this new option, and to evaluate the success of the program in enabling families to chose their PCS workers and to pay them a wage somewhat higher than that currently possible. The percentage of allocated hours actually used will be a measure of success.

In order to expand access to non-Medicaid providers, CSHN has been working with Medicaid in order for CSHN itself to become a Medicaid provider of therapies, contracting with therapists who, as individuals, cannot be Medicaid providers.

CSHN also makes expert pediatric OT and PT available to community-based therapists, for consultation around individual children and for focused training. This support is funded by CSHN through a contract to an outpatient pediatric rehabilitation agency.

Linkages to Promote Provision of Services and Referrals for CSHCN

Linkages that exist to promote provision of services and referrals for CSHCN are largely described above. See Section 1.5.2.1 Program Capacity. The sources of linkages are:

1. The primary care medical home. (See discussion Availability/Capacity for Primary Care above).
2. The Part C early intervention program, the Family, Infant and Toddler Project, which is managed within CSHN; see description under 1.5.1.2 Program Capacity-System of Care for CSHCN-Family Infant and Toddler Project.
3. CSHN Clinic-based services, including nursing coordination and medical social work services;

see description under 1.5.1.2, CSHN Clinics.

4. CSHN regionally-based nursing and medical social work services; see description under 1.5.1.2, Special Services Program.
5. VT Department of Health Healthy Babies and 1-to-5 Program; see 1.5.1.2, first section.

CSHCN Focus Group/Interview/Survey Needs Assessment Data

"We need advocates, not just agency people who refer us along to someone else." "I had 35 different people in my house in less than a year." "I do it all myself with no help. I guess that says it all." Family respondents repeatedly asked that there be collaboration and communication between agencies, schools, and medical care. They expressed their appreciation for providers who served as advocates, attended meetings, helped families cope with applications for assistance, informed them of resources, and coordinated a complex system of providers.

Other Sources of Needs Assessment Data

In many state programs, among them CSHN, FITP, the Division of Developmental Services, and special education, each enrolled child has a nominal nurse coordinator or medical social worker (CSHN), service coordinator (FITP), case manager (DDS or special education). However, the "caseloads" make effective advocacy and coordination a near impossibility. Instead, parents are impressed with the numbers of case managers assigned to them and the extra burden of managing their case managers. For example, the current active children in one region's FITP program number over 120, not including the infants and toddlers who have been referred and are in various stages of evaluation but have not reached the point of having an IFSP. Over 200 children with cleft palate or other craniofacial condition are in the part-time CSHN nurse coordinator's caseload.

Role of the CSHCN Program in Addressing Areas of Need

As described earlier, CSHN has made the Medical Home, a potential source of coordination and advocacy, one of the ten priority areas.

CSHN and FITP continue to report to the co-lead agencies for Part C on the striking growth of the enrollment in the program and the need for adequate resources in addition to the annual federal grant.

CSHN continues to support Parent to Parent in its parent information and training activities.

Existing Resources for Community-based care for CSHCN

See discussions of Financial Barriers to, and Availability/Capacity of, Primary Care and of Habilitative and Rehabilitative Services, above, as well as 1.5.1.2 Program Capacity, System of Care for CSHCN.

Existing Resources for Specialty Care through Pediatric Centers for CSHCN
Existing Resources for Community-based Specialty Clinics for CSHCN

See discussions of Financial Barriers to, and Availability/Capacity of Specialty/Subspecialty Care, above, as well as 1.5.1.2 Program Capacity, System of Care for CSHCN.

3.1.2.4 Population-Based Services

For a complete discussion of programs designed to fill the need for population based services, please refer to Section 1.5.1.2, Program Capacity. See also the discussion about planning in relation to the performance measures in Section 4.1. For a discussion of the State's coordination activities with other groups, please see Section 1.5.2, State Agency Coordination. For related information on health services and planning activities for population based activities, see also sections 3.1.2.2 and 3.1.2.3

Although often included as direct and enabling services, Healthy Babies can also be considered as offering state wide, population based services. This system of organizing community based care for pregnant women and infants is designed to positively influence the MCH priority needs dealing with promoting healthy pregnancies and birth outcomes (ie; priority needs #3, #5, #6, and #7). Recent program planning efforts have concentrated on how to reach the targeted population is a more complete way. This past year, a sizable grant from the Commonwealth Fund will allow for additional planning, evaluation, and expansion of Healthy Babies and the

"1-5 Program". This planning will progress as a cooperative effort between Community Public Health and Medicaid. A key aspect of this effort is to not only to expand services, but also to allow for the assessment of community based service needs for the MCH population. In this assessment process, focus groups are being conducted with health care providers and community nursing and early education organizations to gather information on the supports needed to build a more comprehensive system of care. In addition, focus groups are presently going on which include families who did not receive services. The purpose of these groups is to discover why the families chose to not participate and what services would have been of use to them during pregnancy and during the first year of life. Other aspects of this grant will be to expand services to meet the needs of the MCH population by the following: Beginning T. Berry Brazelton's Touchpoints program in communities statewide, consolidating and expanding the services of Healthy Babies and "1-5", and expanding case management services for children with chronic health conditions (this effort being coordinated with CSHN).

3.1.2.4 Population Based Services for CSHCN

Priority Needs Summary:

- There is a need for development of services and supports to help youth with special health care needs transition to the adult system of care; at the same time, it must be recognized that the adult system of care for individuals with chronic conditions beginning in childhood needs further development in order to be ready to receive the population.

Primary Prevention: Folic Acid Intake for Women of Childbearing Age.

The consistent daily intake of 400 micrograms of synthetic folic acid by women of child bearing age has the potential to reduce the incidence of neural tube defects by as much as 70% in some studies. Although the numbers of Vermont children with neural tube defects is small, and the medical and educational supports for them and their families are substantial, Vermont has made the achievement of the recommended intake of folic acid a goal in its *Vermont Health Plan 1999: A Call to Action*, and its *Vermont Health Action Plan 2000.* VDH, including representation from CSHN, is partnering with the VT Chapter of the March of Dimes to promote the recommended

intake. VDH has made a matching grant to March of Dimes to embark on a vigorous public and professional education campaign. As part of this campaign, the CSHN director authored an article on folate and the recommendations, for the *Vermont Disease Control Bulletin*, distributed to health practitioners statewide.

Secondary Prevention: Newborn Screening--Early Child-Find for CSHCN

Newborn "Bloodspot" Screening: All aspects (management, coordination, availability, funding) of Vermont's newborn "bloodspot" screening program are described under 1.5.1.2 Program Capacity-Preventive and Primary Care. See also Performance Measure #4.

Newborn Hearing Screening: See Performance Measure #10 and State Performance Measure #3. CSHN is increasing efforts to encourage universal newborn hearing screening, with hospital nursery screening as the starting point in a system of assurance. Presently, Vermont does not have a system for assuring that all newborns are screened for congenital hearing loss while in the hospital nurseries. However, in response to the guidance of CSHN's Advisory Council on hearing issues, CSHN partnered with the Vermont Association of Hospitals and Health Systems (VAHHS) and with Fletcher Allen Health Care (FAHC) to establish a statewide network of hearing screening clinics, the Hearing Outreach Project (HOP). In 1999, the legislature required VDH to establish a study commission to determine and report upon what it would take to implement universal newborn hearing screening in VT. The CSHN director chaired this commission. The Executive Summary of this report is contained in the appendix. The report recommended that hospital nurseries be urged to begin UNHS, that VDH could be a source of technical assistance, that HOP evolve from a network of clinics performing targeted hearing screening for young children to a statewide follow up and assurance system for UNHS. These goals could be implemented without any state mandate to do so, following the model of Vermont's newborn metabolic (bloodspot) screening program. At the time of this writing, HOP has collaborated with four community hospitals to the point of their selecting the screening equipment, and two have begun screening all newborns. It seems very likely that other hospitals will participate in the near future. CSHN is positioned to continue to support the effort with technical assistance and follow-up from the Hearing Outreach Project.

Newborn Intensive Care Unit Developmental Follow-up Screening: For many years, VDH has supported a multidisciplinary clinic providing developmental screening for infants who were cared for at the FAHC NICU. In the 1990's this effort evolved from a clinic that saw fewer than 50% of the targeted infants referred (because of a very high "no-show rate"), to a comprehensive triage follow-up system involving primary care physicians, the NICU follow-up clinic, and the CSHN Child Development Clinic depending upon the risk factors the infant demonstrates at discharge. Infants who live at some distance from Burlington (the site of FAHC) are now able to be seen at the CDC held in the community closest to home. The Burlington NICU follow-up site is served by a team from UVM's LEND program and functions as a clinical training site for LEND trainees in many pediatric specialties. Medicaid is tapped as a fee-for-service funding source for eligible children. If on follow-up screening, infants need further evaluation, they are referred to CDC and their community's FITP program. Even more recently, CSHN has provided some support to the Dartmouth NICU Developmental Follow-up effort through the co-funding of the clinic coordinator position, enrollment in CSHN and its Cost Share supports, and care coordination through the CSHN Special Services program. However, no similar collaboration yet exists with other tertiary hospitals providing NICU care to Vermont newborns, such as Albany (NY) Medical Center.

Tertiary Prevention: Transition Services for CSHCN

CSHCN Focus Group/Interview/Survey Needs Assessment Data

Many respondent families expressed concern about their children's health needs begin met as they grow older, and worried about their children aging out of services that had been helpful. The concern about primary care services and specialty services for adolescents and adults with conditions perceived as being pediatric has been described above (see Availability/Capacity for Primary Care).

Other Sources of Needs Assessment Data

With the exception of clinic services for adults with cystic fibrosis, all CSHN programs cease when a child turns 21 years old; the following year, children age out of special education. At age

18, the generous income limits for Medicaid/Dr. Dynasaur end. Programs organized around the needs of individuals with specific chronic conditions such as myelomeningocele, cerebral palsy, PKU, and juvenile rheumatoid arthritis serve only children and youth, generally with no counterparts in Internal Medicine. Indeed, specialty training in Internal Medicine has tended to overlook the care of adults with conditions that used to be fatal in childhood.

Role of the CSHCN Program in Addressing Areas of Need

Vermont has chosen the transition needs of youth with special health needs as one of the ten priority areas. Much remains to be addressed in this area. Vermont CSHN is a participant in the MCHB-funded Measuring and Monitoring project; transition issues comprise one of the six systems objectives for CSHCN in this project. The parents in the CSHCN needs assessment focus groups recommend that CSHN begin with a committee of parents and youth specifically to hear their concerns and recommendations about transition issues. Solutions are likely to involve other state agencies as well as the university and community health care system, requiring the persuasion of data and direct advocacy from parents and youth.

Within CSHN, our clinical practices as children approach adolescence and adulthood need the attention of parents and youth to guide us to provide care that eases the transition to adult services. The CSHN Advisory Committee will be asked to assist us.

3.1.2.5 Infrastructure Building Services

The following is a brief discussion of state efforts to promote comprehensive systems of care and related efforts at assessment, planning and evaluation. See also the discussions in Sections 3.1.2.2 and 3.1.2.3, which also relate to infrastructure planning and support activities. For a discussion on state coordination efforts, see Section 1.5.2.

The three main goals of the Critical Access Hospital Program are as follows, 1) To improve the health of Vermonters living in rural areas, 2) To assure the availability of high quality, coordinated health services for residents of rural Vermont communities, 3) To maintain access to acute and emergency care in rural areas. The program works toward these goals by providing

support to hospitals to receive a designation as a Critical Access Hospital. These hospitals receive assistance in developing comprehensive plans for delivery of coordinated health services to their respective communities. Rural hospitals receive technical assistance in evaluating health status and service delivery and in monitoring and evaluating program effectiveness.

Significant work on quality improvement has been accomplished by VPQ and via its close coordination with the Department of Health. VPQ is a private, not-for-profit organization which provides evaluation and recommended actions for improving health care activities for specific health needs of Vermonters. Recent reports have highlighted the MCH issues of care such as diabetes in children, otitis media in children, and efforts to improve birth outcomes, such as standards for clinical management of vaginal birth after cesarean delivery (VBAC). Recommendations which are in preparation include those dealing with management of asthma in children. Also, upcoming recommendations for the management of diabetes in children will complement the recently developed manual developed by the Department of Health on care of the child with diabetes in the school setting.

Standards of care for pediatrics is partially addressed by the development and implementation of the Health Screening Recommendations for Children and Adolescents. These recommendations reflect several years of intense coordination by such groups as healthcare providers, health maintenance organizations, Medicaid, the Department of Health, physician professional organizations, and the University of Vermont. The resultant periodicity schedule is based on the Bright Futures recommendations, but is Vermont specific and tailored to the needs of Vermont children. Presently, outreach and support activities are being developed to assist providers with implementation.

The maternal/newborn discharge recommendations were developed and implemented statewide in 1998. The purpose of the algorithm is to guide clinical care providers in the best practices for determining hospital discharge guidelines for new mothers and their newborns. Criteria such as parity, clinical conditions, and method of infant feeding are used to guide time of discharge and community health service response. A statewide evaluation of the use and effectiveness of this

tool is now being planned by Fletcher Allen Health Care and the Department of Health.

Significant efforts in improving the quality of care provided by MCH community health visitors have been achieved in the past several years. For example, Healthy Babies has developed refined definitions of competencies and standards of care for both nurses and health outreach workers who visit families with young children via this Medicaid funded program. Educational sessions (often through interactive television format) in competencies and best practices are offered throughout the state for the staff of the Department of Health and for staff who provide Healthy Babies services via community organizations such as home health agencies and parent child centers. In addition, the WIC program has enhanced its comprehensive training agendas for staff.

3.1.2.5 Infrastructure Building Services for CSHCN

Priority Needs Summary:

There is a need for the continued and expanded collaboration with families, through Parent to Parent, in the ongoing assess

- assessment of need and evaluation of services and strategies to meet those needs; such collaboration, if successful, will be beneficial through all levels of the pyramid.

A great deal of the information requested to be provided in this section of this document has already been discussed in other sections. These sections will be referenced below, and supplemented as necessary.

Construct 1. State Program Collaboration with Other State Agencies and Private Organizations (in the Formulation of Policies, Standards, Data Collection and Analysis, Financing of Services, and Program Monitoring)

Medicaid. Collaboration includes participation in prior authorization, advocacy for coverage and policies, participation in planning efforts, Medicaid funding of direct care services for CSHCN and for enabling/care coordination services through EPSDT.

SSI. CSHN through its grant to Parent to Parent provides outreach, information and referral to families with children found newly-eligible for SSI.

Social Services. The CSHN director participates in a now-monthly case management discussion of certain high-risk children who have special health needs and who are in foster care.

Special Education. CSHN participates with Special Education representatives on ad hoc and ongoing task forces.

Early Intervention. The Family, Infant and Toddler project is administered from CSHN.

Vocational Rehabilitation. VR has a written agreement with CSHN about mutual referral of adolescents.

Mental Health and Developmental Disabilities Programs. One of the closest collaborations of CSHN is with the Division of Developmental Services; one of the weakest, with the Division of Mental Health. The CSHN Director has been invited to give a presentation to the Act 264 Advisory Board, a governor-appointed council charged with developing the state plan for children with mental health needs.

Transition. (See 3.1.2.4 Population based Services, above.)

SSDI. SSDI's focus is on meaningful MCH data to guide planning. The SSDI coordinator is able to produce ad hoc reports for CSHN.

Tertiary Medical Centers. (See Availability/Capacity for Specialty/Subspecialty Services, above.)

VT Chapter of the American Academy of Pediatrics The AAP has been immensely helpful in the design of a new periodicity schedule for primary care, for leadership in the Medical Home movement, and for opportunities to use its meeting as a place to explain public health activities that are current and ongoing.

Family and Parent Advocacy Organizations. CSHN's long and fruitful partnership with Parent to Parent continues to grow, as described in several areas in the document.

Construct 2. State Support for Communities (Technical Assistance and Consultation, Education and Training, Common Data Protocols, Financial Resources for Communities Engaged in Systems Development)

CSHN and FITP separately and together provide ongoing training for a variety of community based provider of services to CSHCN. The example of the CSHN Nutrition program is described under 1.3.1.2 Program Capacity. In collaboration with UVM's University Affiliated Programs, FITP annually presents a series of day-long conferences for providers of care to infants and toddlers. These conferences are also open to the larger community as spaces are available.

Construct 3. Coordination of Health Components of Community-based Systems (Among Providers of Primary Care, Habilitative and Rehabilitative Services, Other Specialty Medical Treatment Services, Mental Health Services, and Home Health Care)

This construct is discussed extensively above, under 3.1.2.2, Direct and Enabling Services.

Construct 4. Coordination of Health Services with Other Services at the Community Level (Including Early Intervention, Special Education, Social Services, Family Support Services)

Likewise, this construct is discussed extensively above, under 3.1.2.2, Direct and Enabling Services.

Continuous Quality Assurance for CSHCN: Standards of Care, Guidelines, Monitoring of Program Effectiveness, Approaches to Evaluation of Care

CSHN intends to continue and expand its collaboration with Parent to Parent in the area of quality assurance and needs assessment in the coming years. The needs assessment process utilized for this document has gathered rich and essential information from families of CSHCN and has given direction to the selection of priorities and activities for CSHN. The grant will enable Parent to Parent to analyze and report upon the concerns voiced by the hundreds of families who contact Parent to Parent every year, with concerns and wishes related to each of the six performance outcomes articulated by MCHB/CSHCN for Health People 2010:

1. All CSHCN will receive regular, ongoing comprehensive care within a medical home.

2. All families of CSHCN will have adequate private and/or public insurance to pay for the services they need.
3. All children will be screened early and continuously for special health care needs.
4. Services for CSHCN will be organized in ways that families can use them easily.
5. Families of CSHCN will participate in decision making at all levels and will be satisfied with the services they receive.
6. All youth with special health care needs will receive the services necessary to make appropriate transition to adult life, including adult health care, work and independence.

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3.2 Health Status Indicators

For information on the core and developmental health status indicators, see Sections 5.4, 5.5, 5.6, and 5.7.

3.2.1 Priority Needs

Direct Services

There continues to be a need for enhanced community based supports for families and children. These services need to be coordinated between various agencies so as to most efficiently address the broad determinants of health, such as physical, mental, emotional, cultural and social supports. For CSHCN, there is an urgent need for a greater capacity for a spectrum of home and community-based supports, from in-home high-tech nursing, to personal care services, to respite, to flexible family funding for services and equipment that lie outside those traditionally considered medically necessary.

Enabling Services

For the Enabling services level: For women and families with children, there continues to be a need expressed need for enhancement of the ability of primary care providers to function as Medical Homes. This need is particularly evident for families of children with special health care needs, thereby improving comprehensiveness, collaboration, coordination, information, and advocacy for CSHCN and their families, across all systems of care. Overall attention is needed for defining quality care standards of practice and developing supports for clinical practitioners.

Population Based Services

Community based service need to be coordinated with planning and evaluation efforts to enhance knowledge development as to the most efficient and effective means of serving the pop so as to best influences performance and outcome measures. For CSHCN, there is a need for development of services and supports to help youth with special health care needs transition to the adult system of care; at the same time, it must be recognized that the adult system of care for individuals with chronic conditions beginning in childhood needs further development in order to be ready to receive the population.

Infrastructure Services

There is a need to increase capacity to gather organize data so as to increase the efficient use of its information in assessment, planning and evaluation. In addition, systems need to be enhanced so as to increase access to care and to minimize the number of uninsured and underinsured Vermonters. For CSHCN, there is a need for the continued and expanded collaboration with families, through Parent to Parent, in the ongoing assessment of need and evaluation of services and strategies to meet those needs; such collaboration, if successful, will be beneficial through all levels of the pyramid.

The list of Vermont's selected priority needs is as follows:

1. All children, including those with special health care needs, will receive continuous and comprehensive health care within a medical home.
2. Youth with special health care needs will receive the services necessary for a successful transition to adulthood.
3. Youth and maternal rates of alcohol and tobacco use will be reduced.
4. All children will receive continuous and comprehensive oral health care within a dental home.
5. Fetal and infant death rates will be reduced.
6. Injuries and unnatural deaths in children will be reduced.
7. Maternal and pediatric exposure to environmental hazards will be reduced.
8. The rates of unintended and adolescent pregnancies will be reduced.
9. Families with children with special health needs will have access to individualized, comprehensive home and community based support services.

10. The prevalence of childhood overweight and obesity will be reduced.

3.3 Annual Budget and Budget Justification

The FY01 budgeted amount is based on current activity levels. See Section 2.1 for discussion of year-to-year changes.

3.3.1 Completion of Budget Forms

See ERP Form 2, 3, 4, and 5.

3.3.2 Other Requirements

Maintenance of effort: Total expenditures for FY89 were $3,006,825. Of those expenditures, $1,622,704 were federal Title V funds. Of the non-federal funds, $1,217,028 was required state match, leaving a state overclaim (maintenance of effort) of $167,093.

Continuation Funding and Special Projects: Vermont will use funds only to carry out the purposes of Title V or to continue activities previously conducted under the consolidated health programs. Certain programs continue specific activities previously conducted under the auspices of other authorizing legislation. The programs include: Vermont Regional Genetics Program, Burlington ($151,732) and Addison County Parent Child Center, Middlebury ($32,820). We are continuing funding for the following special projects which were begun before 1981: Comprehensive Obstetrical Services ($58,912) and Vermont Regional Perinatal Services, Burlington ($5,656).

Other federal dollars are those specifically described on Form 4. All non-federal funds are State General Funds appropriated by the legislature.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

See ERP Form "CORE."

3.4.1.1 Five Year Performance Targets

See ERP Form 11.

3.4.2 State "Negotiated" Five Year Performance Measures

See ERP Form 16.

3.4.2.1 Development of State Performance Measures

See ERP Form 16 and Figure 4 below.

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of Medicaid infants from birth through 12 months who receive a home visit through the Healthy Babies system of care.	X					X	
2) The percent of low income children (with Medicaid) that utilize dental services in a year.		X				X	
3) The percentage of Vermont Department of Health (VDH) districts that have a community-based hearing screening and diagnostic follow-up program (Hearing Outreach Program) for children.		X			X		
4) The percent of primary caretakers in the Women, Infants and Children (WIC) program who report placing infants to sleep on their backs as the usual sleeping position.			X				X
5) The percent of youth aged 12-17 who use alcohol.			X				X
6) The percent of 8th grade youth who smoke cigarettes.			X				X
7) The percent of Women, Infants and Children (WIC) program families who use feeding practices that prevent Baby Bottle Tooth Decay (BBTD).			X				X
8) The percent of Vermont Maternal and Child Health (MCH) staff successfully completing cultural competency training.				X	X		
9) The degree to which an accessible, comprehensive data system supports CSHCN policy making, planning, and activities.				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

The state performance measures were developed by the MCH Implementation Team in 1998. The MCH Implementation Team consisted of representation from Community Public Health, Dental Health, Children with Special Health Needs, and the MCH Planning Unit. As part of the ongoing needs assessment process which was begun in 1999-2000, the state measures will be reevaluated and revised as appropriate for ongoing evaluation of state specific population needs. In addition, the methods of communication and collaboration on planning and program development will be reevaluated for the purpose of strengthening infrastructure. This evaluation will be supported by the technical assistance provided by the request for consultation entered in Form 15.

State Performance Measure (SPM) #1, home visits to Medicaid eligible infants through the Healthy Babies system of care, is an indicator for the Direct Health Care Services level of the pyramid. Home visiting is a key component of Healthy Babies because the intense involvement with families through regular visits provides support , opportunities for providing personalized education, and close qualitative monitoring of the health needs of the population being served. Increasing the percent of infants receiving home visits is related to a number of priority needs, including reducing infant mortality from SIDS (parents are educated about recommended sleep position and the dangers of exposing infants to second hand smoke); avoiding feeding practices that promote baby bottle tooth decay (parents are informed of recommended feeding practices); reducing rates of child maltreatment (providing support to parents, information about healthy ways of dealing with stress, and referrals to family support services); increasing childhood immunization levels (follow up with immunization guidelines and encouragement to establish a medical home); and early identification of hearing loss in children (nursing professionals are alert to signs of hearing loss). SPM #1 is also linked to several outcome measures: infant, neonatal, and post neonatal mortality.

SPM#2, the utilization of dental services by low income children, has been a longstanding issue in

Vermont. This performance measure is an indicator of Enabling Services in the pyramid. SPM #2 is clearly related to the newly defined priority need #4, children receiving care through a dental home.

Another indicator of Enabling Services in Vermont is SPM #3, the percent of health districts that have a community based hearing screening and diagnostic follow up program for children. There is a clear link between the availability of screening and diagnostic programs and early identification of hearing loss in children. Identification of hearing loss may well prevent child deaths from accidents or fatal injuries (Priority Need #5).

SPM#4, the percent of WIC caregivers placing infants to sleep on their backs, is an indicator for Population Based Services in the pyramid. This state performance measure is linked to priority needs #5, reduction in fetal and infant deaths, and #6, reduce unnatural deaths in children. Infant sleep position, (prone position) is an established risk factor for SIDS deaths. Reducing SIDS deaths would be expected to impact the post neonatal mortality rate and possible the infant mortality rate as a whole.

SPM#5 is youth alcohol abuse. This performance measure is critical to the state since Vermont has relatively high rates of alcohol use and alcohol related motor vehicle accidents. SPM #5 is related to priority need # 6, reduction of deaths in children, and #3, reduction in alcohol use by youth. This measure related to outcome measure #6, child death rates.

SPM #6, the percent of eighth grade youth smoking cigarettes, is also a Population Based Services indicator. Vermont has persistently high rates of youth cigarette smoking. This performance measure focuses on the eighth grade group as an indicator of cigarette smoking initiation, since prevention is the most effective strategy for reducing smoking related adverse outcomes. This measure is related to priority need #3, reduction in youth rates of tobacco use. In the long-term, this performance measure is also linked to a number of outcomes. Preventing the initiation of smoking among youth is expected to reduce the proportion of infants born to mothers who smoked during their pregnancies and to reduce the proportion of infants exposed to

environmental tobacco smoke from their mothers and from other adults.

The final Population Based Services indicator is SPM #7, the percent of WIC families who use feeding practices that prevent baby bottle tooth decay (BBTD). Data available for FY99 indicate that 90% of caretakers in interviewed in WIC report appropriate feeding practices. Planning is underway to reevaluate this measure and incorporate its findings into other program educational efforts.

An indicator for Infrastructure Building Services level of the pyramid is SPM #8,the percent of staff completing cultural competency training. Since one of the current challenges to the provision of health and human services in Vermont is to competently address the needs of an increasingly diverse population, the focus of this indicator is well timed. This indicator reflects a prevailing philosophy of the importance of cultural competency in improving the efficiency and sensitivity of quality health care services. Planning is underway between the Office of Minority Health and other divisions to develop other, more sophisticated measures which will further reflect the delivery of culturally competent services.

3.4.2.3 Five Year Performance Targets

See ERP Form 11.

3.4.2.4 Review of State Performance Measures

No material included.

3.4.3 Outcome Measures

See ERP Forms (CORE section).

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

Direct Health Care Services

Pregnant Women, Mothers and Infants

Activities related to increasing the proportion of infants receiving home visits through the Healthy Babies system of care (SPM #1) include:

- Continue to enhance the presence of Healthy Babies Nurse Coordinators in local hospitals and to support the collaboration with maternity nurses and medical providers in order to ensure timely referral and enrollment of infants into the program.
- Continue to incorporate limited nursing visits with visits from a Parent Child Center family support worker for those babies not requiring exclusive nursing care. This expands the capacity of the program and encourages the family to continue to receive visits for their baby from a familiar person while transitioning to a new visitor.
- Evaluate completed pediatric client satisfaction surveys to uncover barriers to home visiting, determine what parts of the program are most helpful, and explore areas that could be developed to address newly identified needs.
- Engage Healthy Babies providers in developing strategies to engage more families through local MCH Coalition activities and targeted focus groups.
- VDH will participate in Grand Round meetings with all obstetricians and pediatricians to elicit their help in encouraging clients to accept home visiting.
- MCH Coalitions in each Vermont Department of Health district will review their status and develop specific local strategies to encourage more families to accepting home visiting services.

Children/Adolescents

No material included.

CSHCN

Activities related to increasing the percent of SSI beneficiaries less than 16 years old receiving

rehabilitative services from the CSHN Program (Core Performance Measure #1) include:

- All SSI-eligible children in Vermont receive Medicaid coverage, a very comprehensive set of benefits. In addition, SSI-eligible children can receive direct clinic services and/or care coordination and family support services.
- Children who are not enrolled in CSHN are being contacted by the Children's SSI Coordinators (three parents of children with special health needs) and are assisted in enrolling in the CSHN program or are referred to more appropriate direct services if needed. Such services may include those of the Department of Developmental and Mental Health Services and the Division for the Blind.
- CSHN assists with after-insurance balances and with certain services not covered by Medicaid, and children with SSI are included in this support.

The following are activities related to the degree to which the CSHN Program provides specialty and subspecialty services (including care coordination) not otherwise accessible to its clients (Core Performance Measure #2):

- The Vermont CSHN program organizes and manages a statewide network of multidisciplinary clinics for children with certain chronic conditions. Clinics are offered at no charge to families, although private insurance or Medicaid may be billed. Certain diagnostic and treatments services, which are prescribed or authorized through clinics, are also offered. Services are available to Vermont-resident children, birth to age 21 years, who have a covered condition. Lifelong services are available for individuals who have cystic fibrosis.
- CSHN continues to provide regional medical and social work and/or nursing care coordination to children with special health needs, who do not attend a CSHN clinic.
- CSHN has increased, and will increase further in FY 2001, the collaboration with children's specialty services provided through Dartmouth Hitchcock Medical Center, West Lebanon, NH. CSHN co-funds a DHMC care coordinator for VT children followed in the Child Development Program. CSHN medical social work staff supporting children receiving care at DHMC participate in coordination of their care in their home communities. CSHN will expand the effort begun in FFY 2000 to develop VT/DHMC

multidisciplinary clinics.

- Vermont continues to coordinate with the Shriner's Hospital in Springfield, MA in an effort to ensure collaboration and community-based care for Vermont children with special health needs being treated at the Shriner's Hospital.
- The objective for Core Performance Measure #2 is fully met for children who have CSHN-eligible conditions.

Enabling Services

Pregnant Women, Mothers and Infants

No material included.

Children/Adolescents

The following are activities related to increasing the percent of low income children that utilize dental services (SPM #2):

- Increased fee for reimbursement of dental services under Medicaid by 2-7% to increase participation by dentists, therefore increasing the availability of dental services throughout the state.
- Administer $150,000 in grants to dentists, hospitals, rural health clinics, and schools to expand dental practices, thereby enabling dentists to serve more low-income children.
- Continue meetings between Dental Health Services, dental service providers, and other VDH personnel to address dental access issues.
- Continue to engage the Vermont State Dental Society and Vermont hospitals on increasing utilization of dental services among low income children.
- Search for funding for dental loan repayment to increase the numbers of dentists who see Medicaid children in the state.

CSHCN

The following are activities related to increasing the proportion of health districts in Vermont with a community-based hearing screening and diagnostic follow-up program for children (SPM #3):

- The Hearing Outreach Program (HOP) is now held in every VDH district and in every hospital catchment area. This level of service will continue.
- To build toward universal outpatient hearing screening, the HOP program will continue to accept referrals of children with no known risk factors. An outreach mailing to multiple referral sources in 1999 encouraged further such referrals.

The following activities are related to increasing the percent of the CSHN population who have a medical/health home (Core Performance Measure #3):

- The CSHN Program collaborates extensively with the Office of Vermont Health Access (formerly the Medicaid Division) in the implementation of Vermont's 1115 Waiver. Most children with Medicaid are now enrolling in a primary care case management model called PC Plus.
- CSHN care coordination support will continue to emphasize the central role of primary care as the medical home for children with special health needs, facilitating communication among family, specialty service providers, and primary care.
- The Parent to Parent/CSHN needs assessment (see Needs Assessment section) identified a major gap between parent' having a primary care physician, and the perception of the PCP practice as their child's medical home. This need has resulted in the priority of strengthening the medical home for CSHCN.

Population-Based Services

Pregnant Women, Mothers and Infants

The following are activities related to increasing the proportion of WIC families who are regularly placing their infants to sleep on their backs (SPM #4):

- Campaign literature from the national Back to Sleep campaign will continue to be disseminated to all hospitals (all maternity, newborn and pediatric units) throughout the state, and VDH will continue to request that medical professionals distribute this information to all families of newborns. Materials sent to the hospitals include literature targeted to health professionals as well as other information for parents and caregivers.
- Efforts will be increased to get the Back to Sleep informational materials to child care

providers throughout the state, including licensed child care facilities and day care homes.

- Plans are underway to promote the Back to Sleep campaign and provide hospital staff in-service programs on SIDS at selected hospitals.
- An important strategy of Vermont's SIDS Program is to develop a Back to Sleep media campaign.
- The Healthy Babies system of care and the WIC program will continue their current one-to-one patient education efforts related to recommended infant sleep position and environment.
- The SIDS program will continue to distribute Back to Sleep campaign materials through two toll-free hotlines: the Parents' Assistance Line and the "Help Your Baby; Help Yourself" hotline. Staff at these hotlines enclose Back to Sleep campaign materials along with other materials that are sent in response to information requests, even when the information requested was on a topic other than infant sleep position.
- The SIDS Program will continue to provide home visits to the families, daycare providers and other caregivers of SIDS victims. Home visits include providing information, support, grief counseling, linkage to support systems and ongoing follow-up and education as needed.
- The VDH will continue to conduct SIDS training for all police officers who go through the state police academy. In addition to in-depth training about SIDS, one objective is to raise awareness about the need for noting the exact sleep positions when infant deaths are being investigated, and to carefully document that information so that sleep position is a routinely recorded part of the documentation and so that statistics on sleep position for all SIDS deaths are complete and accurate. These trainings also inform police officers that SIDS deaths can happen in any sleep position and provide information on how questions can be asked in a compassionate manner when discussing an infant's death with parents or other caregivers while conducting an investigation into SIDS death.

The following activities are related to the percent of WIC program families using feeding practices that prevent Baby Bottle Tooth Decay (SPM #7):

- Continue to reimburse dentists for oral hygiene instruction for the parents of children

under age 5 through Medicaid fees established for this purpose.

- Through the Baby Bottle Tooth Decay (BBTD) Initiative, continue to coordinate prevention efforts among primary health care providers, dentists, dental hygienists and VDH staff (Dental Health Services, WIC and EPSDT outreach staff).
- The Healthy Babies and WIC programs will provide information on BBTD (and its prevention) to all new parents and again when the infant is 9-12 months of age.
- The Healthy Babies Program will coordinate BBTD prevention efforts with day care providers, primary care providers, and Dental Health Services.
- The WIC program will continue efforts to prevent BBTD by providing targeted family education and by continuing data collection efforts at ages 6 months and one year in order to establish baseline data and to monitor prevention efforts.

The following activities are related to the percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (Core Performance Measure #4):

- The Vermont Newborn Screening Program will continue to assist hospitals, health care providers and parents, and to assure that the program operates according to current standards of practice, including quality assurance standards.
- The Vermont Newborn Screening Program operations will continue to include program development, sample handling, maintenance of records, communication among all parties for failed screening, and professional education services.
- Data collected by the program will continue to include the number of infants screened, screening results, repeat screens indicated and completed, and follow-up services provided. The number of newborns screened are compared to the total number of Vermont births, and monitoring also takes place regarding the number testing positive who receive appropriate treatment.
- The screening of all newborns born at home remains a program priority, and midwives will continue to be encouraged to ensure that screening takes place.
- Access to newborn screening services will continue to be ensured, regardless of ability to pay the fees for screening services.

The following activities are related to the percent of mothers who breastfeed their infants at hospital discharge (Core Performance Measure #9):

- The MCH Coalitions around the state will continue to lead local communities in breastfeeding awareness and support activities. Many of the coalitions have separate breastfeeding steering committees that address such needs as breast pump availability, coordination with local hospitals, community support services, developing breastfeeding surveys at the 6-month obstetrics visit, and assisting working mothers to continue breastfeeding.
- Continue to train health care professionals to promote breastfeeding among their patients. As part of this effort, VDH and VRPP are developing a series of breastfeeding conferences for professionals which will be transmitted statewide via the telemedicine network.
- Continue to work in collaboration with hospital nursing staff to promote breastfeeding.
- Develop a formal breastfeeding liaison relationship with the state AAP chapter and Vermont ACOG, and the Vermont Lactation Consultant Association.
- Build a strong breastfeeding education component into childbirth education.
- Develop a best practices guide to assist workplaces in supporting their breastfeeding employees.
- Public Health Nursing Chief will chair a statewide breastfeeding task force.
- Collaborate with VRPP to develop a series of breastfeeding conferences to be transmitted statewide via the telemedicine system.

Children/Adolescents

The following activities are related to the percent of youth aged 12-17 who use alcohol (SP #5):

- VDH's Division of Alcohol and Drug Abuse Programs awarded $2.4 million to selected Vermont communities in 1998 under the State Incentive Cooperative Agreement (SICA) funded by the federal Center for Substance Abuse Prevention. The grants support efforts to change community norms regarding the acceptable age of initiation of alcohol use among youth, and to change youth perceptions of the acceptability of alcohol use and

perceptions of harm from early use of alcohol.

- Communities receiving awards will assess the formal and informal community needs and policies addressing youth access to alcohol.
- A Comprehensive Prevention Strategy will be developed that includes standards for community coalitions, policy change, and links with media initiatives.
- The state will develop a coordinated funding system for substance abuse prevention efforts which merges funding streams and ensures that remaining categorical funding programs are coordinated with a Comprehensive Prevention Strategy for the state.
- A research-based, comprehensive prevention strategy for alcohol use among youth is currently in place. All community grantees receive training in the implementation of research-based strategies for preventing youth alcohol use and are provided guidelines for developing program components, e.g., guidelines for the development of media materials.
- Through the efforts of the EPSDT School Access program and collaboration among VDH, the Agency of Human Services Planning Division, the Vermont Department of Education, the Vermont Dental Society, and the University of Vermont, best practices guidelines have been developed for schools in the area of alcohol use prevention and were distributed to schools.
- School prevention components, largely supported by Safe and Drug Free Schools funds, will emphasize research-based practices.
- The Office of Health Promotion Research at the University of Vermont, a partner in the ADAP project, continues with a research project to explore how media advertising can reduce alcohol use. One area of Vermont was selected to receive strong media advertising and community organizing aimed at youth and parents and designed to reduce demand for alcohol use among youth and to change parental norms with regard to youth alcohol use.
- Act 117, which increased penalties for those selling or furnishing alcohol to minors, will continue to be enforced.
- With funds provided through the Office of Juvenile Justice and Delinquency Prevention, ADAP and the Vermont League of Cities and Towns support regional STARTS (Stop Teen Alcohol Risk Teams). These teams are responsible for increased enforcement of the underage drinking law by intervening at underage drinking parties and increasing screening

and intervention services for youth who are arrested.

The following activities are related to the percent of 8th grade youth who smoke cigarettes (SPM #6):

- VDH employs a Youth Tobacco Specialist to work exclusively on youth tobacco issues.
- Thirty grants were awarded to middle schools and programs that serve middle school age youth to implement tobacco prevention activities, including formation of a Statewide Youth Advisory Committee, Operation Storefront, and youth surveys. These activities include a 3-day "Vermont Kids Against Tobacco" training for a 5-member youth team from each school/program on leadership skills and tobacco use prevention strategies.
- Vermont Kids Against Tobacco State House Rally: Grant recipients and other youth groups participating in tobacco prevention activities meet with the governor, commissioner of health, and key legislators to present the results of their activities and to discuss tobacco prevention and control issues from a youth perspective.
- A TV and radio counter-advertising campaign is occurring to discourage pre-adolescents and adolescents from using tobacco.
- The VDH Tobacco Program will participate in, and provide exhibits for, community events, health fairs, conferences and school events. Classroom presentations and workshops will also be offered.
- VDH Tobacco Program staff will also be actively engaged in planning committees and prevention conferences for youth.
- The Coalition for a Tobacco-Free Vermont member organizations will continue to provide a number of school- and community-based programs aimed at youth (e.g., Tar Wars; the Great American Screamout).
- Ten community grantees will participate in a comprehensive program to discourage tobacco use among youth and adults.
- A High School Network, called Vermont Youth Movement Against Tobacco, is being formed that will provide youth with opportunities to design their own local tobacco use prevention programs.
- A Vermont Youth for Truth summit was held in the spring of 2000 for planning for

statewide activities for high school youth.

- Through the efforts of the EPSDT School Access program and collaboration among VDH, the Agency of Human Services Planning Division, the Vermont Department of Education, and the University of Vermont, best practices guidelines have been developed for schools in the area of tobacco use prevention and were distributed to schools.

The following activities are related to the percent of children through age two who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B (Core Performance Measure #5):

- Continue to provide immunization services that are both accessible and affordable.
- The legislation enabling the state of Vermont to set up an immunization registry allows the Vermont Department of Health to work on a pilot program to set up a database of all newborns each year and follow their immunization records through their 18th birthdays.
- The immunization registry will be pilot tested in one geographic region of the state in preparation for statewide expansion. Field visits to other parts of the country will be completed in order to assess the functioning of integrated data systems used for immunization registries in other states.
- Continue to ensure that clients served by public health programs are up to date with their children's immunizations. For example, random sample surveys of the immunization records of children in Community Public Health programs are conducted annually using the Clinical Assessment Software Application (CASA) software from the Centers for Disease Control (CDC). The sample is selected from a name list generated by the VDH Client Management Information System (CMIS).
- Work will continue with child care programs and private providers to ensure that immunizations are kept up to date.
- Work with community partners to provide opportunities for children to receive immunizations and to inform parents, providers, and communities of the importance of immunizations and how to access services.
- Provide information and education on childhood immunizations at home visits and parenting classes.

- Pediatricians and Family Practitioners throughout Vermont will receive a "Provider's Toolkit" as part of the implementation of the newly developed Vermont Health Screening Recommendations for Children and Adolescents.
- A similar product (such as the above mentioned toolkit) will be developed for parents to assist them in understanding normal development and to prepare for upcoming health care visits and immunizations.
- The Department of Health will collaborate closely with University of Vermont School of Medicine's Department of Pediatrics to implement VCHIP (Vermont Child Health Improvement Project).

The following activities are related to the birth rate for teenagers aged 15 through 17 (Core Performance Measure #6):

- The efforts of the Adolescent Pregnancy Prevention Task Force will continue.
- Continue support for comprehensive health education through the participation of the MCH Director on the Comprehensive Health Education Advisory Committee and the Adolescent Health Task Force.
- Continue support for integrated health education, social services and community-based systems of care for adolescents, including "wrap around services" for high-risk youth.
- Continue to ensure access to comprehensive health services, including family planning and reproductive health services, to Vermont youth.
- Continue to support community discussions and education about abstinence and pregnancy prevention.
- Continue efforts to reduce rates of child abuse, including sexual abuse.
- Continue to support programs for pregnant and parenting teens that can reduce the probability of repeat pregnancies.
- Continue to support drop out prevention activities.

The following activities are related to the percent of third grade children who have received protective sealants on at least one permanent molar tooth (Core Performance Measure #7):

- A sealant initiative for schools is being implemented in twenty schools via the Tooth Tutor

program which will target children at risk (those without sealants, according to the school health history form). Those children will be given a pamphlet for their parents that outlines why it is important to go to the dentist and provides promotional information about protective sealants.

- As part of the school initiative, literature and posters promoting the use of sealants will be distributed to all elementary schools.
- By the fall of 2000, approximately forty schools will be participating in the EPSDT Tooth Tutor Program (formerly known as the Ten-Step Plan) Using an EPSDT best practice protocol, school have a tool to target children on Medicaid who need dental care and can collaborate with local dentists to provide a dental home.

The following activities are related to the rate of deaths to children aged 1-14 caused by motor vehicle crashes (Core Performance Measure #8):

- The Vermont Department of Health (VDH) will continue its work with the Governor's Highway Safety Program on the prevention of motor vehicle crashes and will offer subsidized care seats to low income families for a nominal co-payment of $10 per seat.
- Nationally certified staff in the 12 district offices of the VDH will continue to provide training in the proper installation and use of child safety seats.
- In 2001, 1,000 subsidized car seats are expected to be provided, at a nominal co-payment rate, to low income Vermont families.
- Also in 2001, 1,000 trainings on appropriate installation and use will be provided to low income families.
- VDH will participate in community-wide child safety seat awareness and training events.
- The Health Department will work with the Governor's Highway Safety Program to develop and pursue a strategy for procuring sustained funding to subsidize the purchase of child safety seats for low-income families.
- VDH will continue to be engaged in substance abuse prevention efforts in order to reduce the prevalence of driving under the influence of alcohol/drugs.

CSHCN

See Core Performance Measures #3, #4 and #10, above.

The following activities are related to the percent of newborns who have been screened for hearing impairment before hospital discharge (Core Performance Measure #10):

- Vermont has completed the planned expansion of the Hearing Outreach Project (HOP).
- HOP has engaged in an outreach efforts to increase targeted referrals and has also publicized its acceptance of referrals of newborns with no risk factors. One hospital refers all its newborns to HOP, as do several pediatric practices.
- The CSHN director has met with hospital CEO's to encourage the initiation of universal newborn hearing screening in hospital nurseries; several hospital have begun and more are planning to screen.
- HOP will continue to provide technical assistance to hospitals as they get ready for universal screening. In addition, HOP will expand, as each hospital begins screening, its assistance with post-screening follow up, referral, and tracking. HOP currently has a protocol for the follow up of NICU babies cared for at FAHC, and provides follow up for babies at the hospitals now screening.

Infrastructure Building Services

Pregnant Women, Mothers and Infants

The following activities are related to the percent of Vermont MCH staff successfully completing cultural competency training (SPM #8):

- Continue to provide the first tier of cultural competency training for MCH staff who are newly hired.
- Implement training in crosscultural management to all MCH management staff.
- Increase the offering of additional cultural competency training opportunities.

NOTE: State Performance Measure #8 cuts across all three population groups being served by the Title V program (not just Pregnant Women, Mothers and Infants).

The following activities are related to the percent of very low birth weight live births (Core Performance Measure #16):

- VDH will continue to support activities related to decreasing rates of cigarette smoking during pregnancy, including smoking cessation counseling and referral to cessation programs.
- Improve WIC outreach to ensure that all pregnant women have a nutritionally adequate diet such that the minimum recommended weight gain is achieved.
- Continue efforts to reduce the birth rate among adolescents.
- The Healthy Babies system of care will conduct in-depth assessments at program entry of risk factors contributing to poor pregnancy outcomes (e.g., intrauterine growth retardation, preterm labor).
- The Healthy Babies system of care will continue to formulate care plans for women that are appropriate to the level of care required to avoid having a low birth weight infant (e.g., referral for smoking cessation, drug treatment, nutritional counseling, education regarding recognizing the signs of preterm labor).
- The Healthy Babies system of care will increase the use of home visiting as an opportunity to provide intervention strategies to help minimize low birth weight.
- Intervention strategies will be formulated to optimize the management of multiple births.
- The Healthy Babies system of care will, when indicated, provide support for women restricted to bed rest because of their risk of premature delivery.

The following activities are related to the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (Core Performance Measure #17):

- The Healthy Babies system of care will formulate plans to assure risk appropriate care so that preterm births occur in tertiary hospitals.
- The regionalized system of neonatal intensive care services will continue efforts to increase the proportion of very low birth weight infants delivered at tertiary care facilities.
- The VDH will continue to provide financial support to the Vermont Regional Perinatal Program at UVM, which monitors perinatal statistics including high risk pregnancies and deliveries and meets with hospitals to participate in annual reviews at the local level. Presented at these meetings are clinical reviews of all infants who were transported to a tertiary hospital.

The following activities are related to the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (Core Performance Measure #18):

- The Healthy Babies system of care will continue to identify barriers to women receiving early care and design programs to help women and their families overcome these barriers.
- Outreach activities to women thinking of becoming pregnant, or who are early in their pregnancies, will be continued to inform them of the benefits of early prenatal care.
- The Healthy Babies system of care will improve communication and outreach to the obstetrical provider community to facilitate women entering care in the first trimester.
- The Vermont Health Access Plan (VHAP) will continue to provide coverage to Vermonters who were previously uninsured.

Children/Adolescents

The following activities are related to the percent of children without health insurance (Core Performance Measure #12):

- Vermont has expanded its Medicaid/Dr. Dynasaur program to cover children up to 300% of the Federal Poverty Level (FPL). These children will be enrolled in Vermont Medicaid's Primary Care Case Management Plan. With the expansion, an additional 1,600 children are expected to be eligible for enrollment.
- Vermont began a CHIP outreach effort, including a component as part of the CISS Health Systems Development in Child Care grant program where parents and child care providers will be informed about accessing free and low-cost health insurance.
- Every family who comes into contact with VDH staff will continue to be screened to determine if they have adequate insurance coverage for health care, including preventive services. Those without adequate coverage will be encouraged to apply for Medicaid benefits. A common, one-page application for health department services (including WIC) and Medicaid will be used to facilitate enrollment in Medicaid, and can be filed at any health or welfare office, allowing for simpler access to services.
- VDH, working through school nurses, continues to regularly distribute flyers to every school aged child in Vermont which describe the Dr. Dynasaur program and its toll free

number.

- In FY01, school nurses will ask every family about health insurance status. As families are identified, a report will be compiled the Department of Education and shared with the Department of Health.

The following activities are related to the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program (Core Performance Measure #13):

- CHIP's outreach effort will be implemented to promote use of the Medicaid program and its services.
- One component of the CISS Health Systems Development in Child Care grant program will be to inform parents and child care providers about accessing Medicaid benefits.
- Families coming into contact with VDH staff will not only be screened to determine if they have adequate health insurance coverage for health care, but will be assisted in applying for Medicaid and encouraged to utilize services offered under the program.
- DSW will develop the process of creating listings by school supervisory unions of the percent of Medicaid eligible children without third party insurance who have received an EPSDT visit.

The following activities are related to the rate of suicide deaths among youth ages 15-19 (Core Performance Measure #15):

- The Child Fatality Review Committee has a subcommittee focusing on youth suicide and reviews each suicide death in detail to determine and recommend prevention efforts.
- The Division of Health Improvement is working with the Child Fatality Review Committee to develop a data collection system and database to systematically assess factors that may be related to youth deaths from suicide.
- The MCH Planning Specialist and the Child Fatality Review Committee will coordinate closely with the newly established Injury Prevention Project.
- The Agency of Human Services Planning Division will be producing a "What Works" document focusing on Youth Suicide Prevention. The AHS Planning Division is producing a series of "What Works" documents, each focusing on a different topic area,

and these documents will be distributed widely throughout the Vermont Agency of Human Services Departments, including the Department of Health.

- VDH will encourage all schools to have suicide prevention protocols in place.

CSHCN

The following activities are related to the degree to which an accessible, comprehensive data system supports CSHN policy making, planning and activities (SPM#9):

- CSHN will seek permission to contract with a programmer/system developer to continue the work already begun on an accessible CSHN patient information system database. Work has been completed to stabilize the existing Cost-Share database, and to add the Respite care database.
- CSHN will continue to offer program-wide staff training in MS Office, Access, and Excel.
- CSHN will support the department's IS unit in their development of a Rationally Unified Process of System Development now getting underway. No commercially produced software has been found to support the department's needs.

CSHN

The following activities are related to the percent of children with special health needs in the CSHN program with a source of insurance for primary and specialty care (Core Performance Measure #11):

- The percentage of children with a source of comprehensive insurance is expected to increase modestly because of the increase in the allowable family income (up to 300% FPL) for Medicaid/Dr. Dynasaur eligibility and promotion efforts currently underway.
- CSHN staff will continue to encourage CSHN families to enroll in Medicaid and will facilitate the application process as much as possible.

The following activities are related to the degree to which the state assures family participation in program and policy activities in the State Children with Special Health Care Needs program (Core Performance Measure #14):

- Through CSHN funding of Parent to Parent of Vermont, CSHN has expanded and will

maintain the SSI support for one to three Children with SSI Coordinators, providing outreach on a closer-to-home basis for Vermont families whose children are eligible for SSI.

- As a result of the Title V Needs Assessment process, the benefit of engaging with families, through Parent to Parent, in the ongoing evaluation of CSHN services, was made clear and compelling. CSHN will expand its support to Parent to Parent for needs assessment and evaluative services in an annual basis.
- CSHN will continue to elicit input from the five CSHN clinical staff who are parents of children with special health needs.
- Parents will continue to serve in a leadership role for the diabetes needs assessment.
- Parents will continue to be active members of the CSHN Advisory Council, the group which helps evaluate and recommend revision of CSHN services. The Council is co-chaired by a parent.

4.2 Other Program Activities

Vermont's toll-free, confidential telephone MCH information and referral service is called "Help Your Baby, Help Yourself," nicknamed the HelpLine (see Form 9). It operates Monday through Friday from 7:45 AM to 7:45 PM and is run by specially trained staff at the Agency of Human Services. Although a wide variety of calls are received, most are in some way pregnancy related. Frequently these calls are for assistance in finding a provider, health insurance, or other resources, such as local childbirth education classes. Requests for non-clinical information only can often be handled over the phone or by mailing out appropriate health education materials compiled and maintained by HelpLine staff.

Calls needing follow-up by public health nurses are immediately referred by the staff person taking the call to the appropriate Vermont Department of Health District Office offering services in the caller's area. A public health nurse contacts the person requesting information or service within twenty-four hours, or immediately if the situation dictates. A list of on-call nurses ensures that emergency calls that come in after normal business hours Monday through Friday can be addressed. All callers are evaluated to see if they are eligible for enrollment in the statewide Healthy Babies System of Care, WIC, EPSDT, or other appropriate services. If appropriate, a

clinic appointment or home visit can be scheduled during the call. All call sheets are reviewed by public health nursing supervisors at the local level and by a public health nursing specialist in the VDH central office.

A vigorous media campaign was run from 1989 through 1992, earning the Healthy Mothers, Healthy Babies National Achievement Award in 1992. Since that time, outreach has been more low-key and much less costly, involving the human services section of the phone directory, posters and flyers, and word-of-mouth.

See section 1.5.2 for information on the coordination of the Title V program with EPSDT, other state and federal programs, and providers of services.

4.3 Public Input

Ongoing public input for Title V programs takes a variety of forms. The public budget process is one opportunity: the governor's budget is published in the newspaper and scrutinized by various advocacy groups and members of the public. Also, a yearly legislative committee session is purposely advertised for public attendance to allow an opportunity for input into Title V and other federal grant applications. The Division of Community Public Health has conducted focus groups on behalf of the WIC and EPSDT programs in the past year to assess satisfaction with programs and services, and to solicit input for suggested improvements as well as additional services. CSHN partners vigorously with parents (including parents of CSHCN who are not served or are not eligible for CSHN programs) through Parent to Parent and its facilitated focus groups, surveys and interviews. Also, the needs assessment process included obtaining input from community based groups with an interest in maternal and child health. In addition, the Title V Application /Annual Report is available to the public through every Department of Health District Office.

4.4 Technical Assistance

See ERP Form 15.

A technical assistance request was obtained in November, 1999 by a MCH epidemiologist to focus on infant mortality and low birth weight. The Divisions of Health Improvement and Community Public Health are requesting technical assistance for a consultant to evaluate internal

methods of communication and collaboration so as to promote systems change. The overall goal is to increase effectiveness of planning and service delivery activities.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year' s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN

include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available, and
3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed

in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies <u>other</u> than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:
(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned

agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Forms

5.5 National “Core” Performance Measure Detail Sheets

5.6 State "Negotiated" Performance Measure Detail Sheets

5.7 Outcome Measure Detail Sheets